

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13061

CERTIFICATE OF DEATH

13057

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 12	
d. NAME OF HOSPITAL (If not in hospital, give street-address) OR INSTITUTION Pen Gen Hospital		e. STREET ADDRESS 413 Martin St	
3. NAME OF DECEASED (Type or print) ATWOOD First BEDSWORTH Middle NOV. Last 24th Day 19 Year 58		4. DATE OF DEATH	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Single DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 29, 1903
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME George H. Bedsworth		14. MOTHER'S MAIDEN NAME Sallie Windsor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W. #2		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Pearl Bolen (Sister) Address P.O.B. # 194 Fruitland Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Broncho-pulmonary Septicemia DUE TO Adenoma of lungs; Bronchitis; Tuberculosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) to Acute Broncho-pulmonary Septicemia DUE TO (c) Septicemia	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/24/58 , 19 58 , to 11/24 , 19 58 , that I last saw the deceased alive on 11/24/58 , 19 58 , and that death occurred at M , from the causes and on the date stated above.			
ACTUAL SIGNATURE Carrie I. Hearn M.D.		ADDRESS (Street, city or town, state) 226 N. Division St. Salisbury, Maryland DATE SIGNED Nov. 25/1958	
PHYSICIAN'S NAME (Type) Dr. Carrie I. Hearn		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF Nov. 27, 1958		22c. NAME OF CEMETERY OR CREMATORY Oriole Cemetery	
22d. LOCATION (City, town, or county) (State) Oriole, Maryland		23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR NOV 26 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hearn	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

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13116

CERTIFICATE OF DEATH

13058

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hebron</u>				c. LENGTH OF STAY IN 1b <u>Home</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hebron General Hospital</u>				d. STREET ADDRESS <u>Hebron Box 372</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Marvin A.</u> Middle <u>Birckhead</u> Last <u>Birckhead</u>				4. DATE OF DEATH Month <u>11</u> Day <u>7</u> Year <u>1958</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>col.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/24/ 1890</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u>68</u> Days <u>68</u> Hours <u>68</u> Min. <u>68</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labor</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Noah Birckhead</u>				14. MOTHER'S MAIDEN NAME <u>Marry E. West</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>Sarah M. Birckhead Hebron MD. box 372</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary arteriosclerosis</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension, essential</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>1956</u> , to <u>Nov 7th</u> , 1958, that I last saw the deceased alive on <u>November 1st</u> , 1958, and that death occurred at <u>6:30 A.</u> M, from the causes and on the date stated above.							
ACTUAL PHYSICIAN'S NAME (Type) <u>L. V. Sohler</u>				ADDRESS (Street, city or town, state) <u>303 East Street Delmar Md.</u>			
DATE SIGNED <u>11-8-58</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>11/13/ 58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>green acres</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton E. Stewart Salisbury Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 11 7 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED MURPHY, J. OLIVER		2. SEX MALE		3. AGE 45	
4. DATE OF DEATH 1914		5. TIME OF DEATH 10:30		6. PLACE OF DEATH HOME	
7. CAUSE OF DEATH HEART DISEASE		8. DISEASE OR INJURY HEART DISEASE		9. PLACE OF BIRTH IRELAND	
10. OCCUPATION LABORER		11. MARITAL STATUS MARRIED		12. EDUCATION 8 YEARS	
13. PREVIOUS ILLNESS HEART DISEASE		14. PRESENT ILLNESS HEART DISEASE		15. MEDICAL HISTORY HEART DISEASE	
16. PHYSICIAN'S SIGNATURE J. H. HARRIS		17. SIGNATURE OF DECEASED J. OLIVER MURPHY		18. SIGNATURE OF WITNESS J. H. HARRIS	
19. SIGNATURE OF DECEASED J. OLIVER MURPHY		20. SIGNATURE OF WITNESS J. H. HARRIS		21. SIGNATURE OF WITNESS J. H. HARRIS	
22. SIGNATURE OF WITNESS J. H. HARRIS		23. SIGNATURE OF WITNESS J. H. HARRIS		24. SIGNATURE OF WITNESS J. H. HARRIS	
25. SIGNATURE OF WITNESS J. H. HARRIS		26. SIGNATURE OF WITNESS J. H. HARRIS		27. SIGNATURE OF WITNESS J. H. HARRIS	
28. SIGNATURE OF WITNESS J. H. HARRIS		29. SIGNATURE OF WITNESS J. H. HARRIS		30. SIGNATURE OF WITNESS J. H. HARRIS	
31. SIGNATURE OF WITNESS J. H. HARRIS		32. SIGNATURE OF WITNESS J. H. HARRIS		33. SIGNATURE OF WITNESS J. H. HARRIS	
34. SIGNATURE OF WITNESS J. H. HARRIS		35. SIGNATURE OF WITNESS J. H. HARRIS		36. SIGNATURE OF WITNESS J. H. HARRIS	
37. SIGNATURE OF WITNESS J. H. HARRIS		38. SIGNATURE OF WITNESS J. H. HARRIS		39. SIGNATURE OF WITNESS J. H. HARRIS	
40. SIGNATURE OF WITNESS J. H. HARRIS		41. SIGNATURE OF WITNESS J. H. HARRIS		42. SIGNATURE OF WITNESS J. H. HARRIS	
43. SIGNATURE OF WITNESS J. H. HARRIS		44. SIGNATURE OF WITNESS J. H. HARRIS		45. SIGNATURE OF WITNESS J. H. HARRIS	
46. SIGNATURE OF WITNESS J. H. HARRIS		47. SIGNATURE OF WITNESS J. H. HARRIS		48. SIGNATURE OF WITNESS J. H. HARRIS	
49. SIGNATURE OF WITNESS J. H. HARRIS		50. SIGNATURE OF WITNESS J. H. HARRIS		51. SIGNATURE OF WITNESS J. H. HARRIS	
52. SIGNATURE OF WITNESS J. H. HARRIS		53. SIGNATURE OF WITNESS J. H. HARRIS		54. SIGNATURE OF WITNESS J. H. HARRIS	
55. SIGNATURE OF WITNESS J. H. HARRIS		56. SIGNATURE OF WITNESS J. H. HARRIS		57. SIGNATURE OF WITNESS J. H. HARRIS	
58. SIGNATURE OF WITNESS J. H. HARRIS		59. SIGNATURE OF WITNESS J. H. HARRIS		60. SIGNATURE OF WITNESS J. H. HARRIS	
61. SIGNATURE OF WITNESS J. H. HARRIS		62. SIGNATURE OF WITNESS J. H. HARRIS		63. SIGNATURE OF WITNESS J. H. HARRIS	
64. SIGNATURE OF WITNESS J. H. HARRIS		65. SIGNATURE OF WITNESS J. H. HARRIS		66. SIGNATURE OF WITNESS J. H. HARRIS	
67. SIGNATURE OF WITNESS J. H. HARRIS		68. SIGNATURE OF WITNESS J. H. HARRIS		69. SIGNATURE OF WITNESS J. H. HARRIS	
70. SIGNATURE OF WITNESS J. H. HARRIS		71. SIGNATURE OF WITNESS J. H. HARRIS		72. SIGNATURE OF WITNESS J. H. HARRIS	
73. SIGNATURE OF WITNESS J. H. HARRIS		74. SIGNATURE OF WITNESS J. H. HARRIS		75. SIGNATURE OF WITNESS J. H. HARRIS	
76. SIGNATURE OF WITNESS J. H. HARRIS		77. SIGNATURE OF WITNESS J. H. HARRIS		78. SIGNATURE OF WITNESS J. H. HARRIS	
79. SIGNATURE OF WITNESS J. H. HARRIS		80. SIGNATURE OF WITNESS J. H. HARRIS		81. SIGNATURE OF WITNESS J. H. HARRIS	
82. SIGNATURE OF WITNESS J. H. HARRIS		83. SIGNATURE OF WITNESS J. H. HARRIS		84. SIGNATURE OF WITNESS J. H. HARRIS	
85. SIGNATURE OF WITNESS J. H. HARRIS		86. SIGNATURE OF WITNESS J. H. HARRIS		87. SIGNATURE OF WITNESS J. H. HARRIS	
88. SIGNATURE OF WITNESS J. H. HARRIS		89. SIGNATURE OF WITNESS J. H. HARRIS		90. SIGNATURE OF WITNESS J. H. HARRIS	
91. SIGNATURE OF WITNESS J. H. HARRIS		92. SIGNATURE OF WITNESS J. H. HARRIS		93. SIGNATURE OF WITNESS J. H. HARRIS	
94. SIGNATURE OF WITNESS J. H. HARRIS		95. SIGNATURE OF WITNESS J. H. HARRIS		96. SIGNATURE OF WITNESS J. H. HARRIS	
97. SIGNATURE OF WITNESS J. H. HARRIS		98. SIGNATURE OF WITNESS J. H. HARRIS		99. SIGNATURE OF WITNESS J. H. HARRIS	
100. SIGNATURE OF WITNESS J. H. HARRIS		101. SIGNATURE OF WITNESS J. H. HARRIS		102. SIGNATURE OF WITNESS J. H. HARRIS	

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BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13062

CERTIFICATE OF DEATH

Reg. Dist. No. 13059

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 147 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS 14x-2			
3. NAME OF DECEASED (Type or print) First William Middle Bond Last Bond				4. DATE OF DEATH Month November Day 20 Year 19 58			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 21, 1897	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months 61 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm laborer	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME unk.		14. MOTHER'S MAIDEN NAME Elizabeth Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) WW 1		16. SOCIAL SECURITY NO. 222-12-4309		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO General arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Varicose ulcer of left leg; secondary anemia. (c) Varicose ulcer of left leg; secondary anemia.						INTERVAL BETWEEN ONSET AND DEATH Yrs Yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Varicose ulcer of left leg; secondary anemia.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 o. m. 0 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 26, 1958 , to Nov. 20, 1958 , that I last saw the deceased alive on Nov. 20, 1958 , and that death occurred at 7:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 11/20/58							
ACTUAL SIGNATURE G. Kosmahly		M.D. Deer's Head State Hospital					
PHYSICIAN'S NAME (Type) G. Kosmahly, M. D.		Salisbury, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 23, 1958		22c. NAME OF CEMETERY OR CREMATORY Pomona		22d. LOCATION (City, town, or county) (State) near Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Walcott				ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DATE NOV 25 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13063

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharptown MD.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Baby Boy Attie</u> First Middle Last <u>Brown</u>		4. DATE OF DEATH Month <u>November</u> Day <u>28</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/27/1958</u>
9. AGE (In years last birthday) yrs. <u>11</u> Months <u>11</u> Days <u>1</u> Hours <u>15</u> Min.		10. AGE (In years last birthday) yrs. <u>11</u> Months <u>11</u> Days <u>1</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Walter Brown</u>		14. MOTHER'S MAIDEN NAME <u>Nettie Morris</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Walter Brown Sharptown Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>atelectasis, fetal type</u> 762.5 DUE TO <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prematurity</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/28</u> , 19 <u>58</u> , to <u>11/28</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/28</u> , 19 <u>58</u> , and that death occurred at <u>3:15 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. W. Saunderson, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>702 Camden Avenue</u> DATE SIGNED <u>12/3/58</u>	
PHYSICIAN'S NAME (Type) <u>R. W. Saunderson, Jr., M. D.</u>		<u>Salisbury, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/2/1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Sharptown</u>		22d. LOCATION (City, town, or county) (State) <u>Sharptown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton F. Stewart</u> ADDRESS <u>Salisbury, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 5 '58</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

1908

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13117

CERTIFICATE OF DEATH

Reg. Dist. No.

13061

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela Springs		c. LENGTH OF STAY IN 1b 71 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD # 1		e. STREET ADDRESS RFD # 1	
3. NAME OF DECEASED (Type or print) First Sherman Middle Edward Last Brown		4. DATE OF DEATH Month Nov. Day 8, Year 1958	
5. SEX Male	6. COLOR OR RACE Col	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 2, 1887
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Farm owner	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel Brown		14. MOTHER'S MAIDEN NAME Mary Virginia Molock	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 212-16-7398	
17. INFORMANT Bessie Brown, Mardela Springs, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis (Coronary) 610X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Nephrosis (c) Prostatic Hypertrophy		INTERVAL BETWEEN ONSET AND DEATH 36 hrs. 14 yrs. 34 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 1 , 19 58 , to Nov 8 , 19 58 , that I last saw the deceased alive on Nov 8 , 19 58 , and that death occurred at 11:01 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE H. S. Kuhlman		DATE SIGNED 11/10/58	
PHYSICIAN'S NAME (Type) H. S. Kuhlman		ADDRESS (Street, city or town, state) Sharytown Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-12-58	
22c. NAME OF CEMETERY OR CREMATORY Zion		22d. LOCATION (City, town, or county) (State) Mardela Springs, Md. RFD	
23. FUNERAL DIRECTOR'S SIGNATURE Charles W. Spayton, Inc.		24. REC'D BY REGISTRAR NOV 13 1958	
ADDRESS Sharytown, Md		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13064

CERTIFICATE OF DEATH

Reg. Dist. No.

13062

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 12			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 618 S.Division St				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) IDA First E Middle CANNON Last				4. DATE OF DEATH NOV. Month 9th Day 19 Year 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 20, 1893	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months 6 Days 5 Hours 15 Min.		IF UNDER 24 HRS. Months 6 Days 5 Hours 15 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Salisbury, Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME George Pusey				14. MOTHER'S MAIDEN NAME Annie E. Quillin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Mr. Lemuel M. Cannon (Husband) Address 618 S.Div.St. Salisbury, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro Vascular Accident 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio Vascular Disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 10-12 , 19 53 to 11-8 , 19 58 , that I last saw the deceased alive on 11/8/58 , 19 58 , and that death occurred at 3:45A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE AC Mitchell				ADDRESS (Street, city or town, state) 211 Maryland Ave DATE SIGNED Nov. 10 / 1958			
PHYSICIAN'S NAME (Type) Dr. Andrew C. Mitchell				Maryland Ave. Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 11, 1958		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND				24a. REC'D BY REGISTRAR DATE NOV 12 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]		RACE [Faint text, possibly "White"]	
DATE OF DEATH [Faint text, possibly "Jan 15 1920"]		TIME OF DEATH [Faint text, possibly "10:00 AM"]		PLACE OF DEATH [Faint text, possibly "Home"]		CITY [Faint text, possibly "Baltimore"]	
COUNTY [Faint text, possibly "Baltimore"]		STATE [Faint text, possibly "Maryland"]		MARITAL STATUS [Faint text, possibly "Married"]		OCCUPATION [Faint text, possibly "Teacher"]	
CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]		MEDICAL HISTORY [Faint text, possibly "Hypertension"]		PRESENT ILLNESS [Faint text, possibly "Stroke"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF REGISTRAR [Faint signature]		SIGNATURE OF WITNESS [Faint signature]		SIGNATURE OF DECEASED [Faint signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13065

CERTIFICATE OF DEATH

13063

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 3 yrs 1 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Secretary 09X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jennie Middle Lee Last Carroll				4. DATE OF DEATH Month Nov. Day 4 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/5/1867	
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ?		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME John Merrick				14. MOTHER'S MAIDEN NAME Louise LeCompte			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, general DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH Years Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 6, 1955 , to November 4, 1958 , that I last saw the deceased alive on November 3, 1958 , and that death occurred at 6:15 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 11/4/58 ACTUAL SIGNATURE L. V. Maldve M.D. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D. Salisbury, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Nov 10		Nov 10		East New Market		East New Market, Md	
23. FUNERAL DIRECTOR'S SIGNATURE J. H. Willoughby				24a. REC'D BY REGISTRAR NOV 7 58		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
				</																			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Item 2 Film 236 12-8-58 et

13066

CERTIFICATE OF DEATH

13064

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury (Rural)</u> 310 E. Vine St.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>Salisbury Lee Nursing Home</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE</u> <u>CECIL</u>				4. DATE OF DEATH Month Day Year <u>NOVEMBER</u> <u>22</u> 19 <u>58</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 30 - 1877</u>		9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>1</u> <u>22</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Grayson</u>				14. MOTHER'S MAIDEN NAME <u>Mary Jane Sommers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Louis H. Stevens - 6116 18th Road N. Arlington Virginia</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Severe, sudden hemorrhage from cancer</u> 151X DUE TO <u>Stomach</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>cancer of stomach</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 23, 1958</u> , to <u>Nov 23</u> , 19 <u>58</u> that I last saw the deceased alive on <u>Nov 23</u> , 19 <u>58</u> , and that death occurred at <u>8:25</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Carrie Hearn</u> M.D.				ADDRESS (Street, city or town, state) <u>Nov. 25/1958</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>Dr. Carrie I. Hearn</u>				226 N. Division St. Salisbury, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Nov. 26, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u> ADDRESS <u>SALISBURY MARYLAND</u>				24a. REC'D BY REGISTRAR <u>NOV 26 '58</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hearn</u>	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

10088

James M. Thompson
born in Illinois, Jan. 1, 1865
died in Illinois, Jan. 1, 1915

James M. Thompson

Jan. 1, 1915

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1
M
13118
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 13065

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fruitland				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# 1 Salisbury Route				d. STREET ADDRESS R.D.# 1 Salisbury Route			
3. NAME OF DECEASED (Type or print) SILAS WILSON CHAPMAN				4. DATE OF DEATH NOV. 26th 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 27, 1873	
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR 9 Months 29 Days		IF UNDER 24 HRS. 19 Hours 58 Min.		10. CITIZEN OF WHAT COUNTRY? U S A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee of Wood-Working Co. (Retired)				10b. KIND OF BUSINESS OR INDUSTRY Carpenter			
11. BIRTHPLACE (State or foreign country) Stockton, Maryland				12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME William K. Chapman				14. MOTHER'S MAIDEN NAME Mary E.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. Mrs. Bettye M. Chapman (Wife)			
17. INFORMANT R.D.#1 Sal. Md. Fruitland, Maryland				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Ascending Colon 153.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from August , 19 58 , to Sept , 19 58 , that I last saw the deceased alive on Sept. 17, 1958 , and that death occurred on 6:30P M, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Pine Bluff Rd. Salisbury, Md. DATE SIGNED Nov. 28 /1958			
ACTUAL SIGNATURE Thomas C. Hill				PHYSICIAN'S NAME (Type) Dr. Thomas C. Hill			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Nov. 30, 1958			
22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery				22d. LOCATION (City, town, or county) (State) Salisbury, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND				24a. REC'D BY REGISTRAR DEC 2 '58 24b. REGISTRAR'S SIGNATURE Arthur L. Frank			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
JAMES H. HARRIS		Male		45		Jan 15, 1900		Baltimore, Md.	
6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. SIGNATURE OF PHYSICIAN	
Clerk		Heart Disease		Home		10:30 AM		J. H. Harris	
11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESSES		13. SIGNATURE OF CLERK		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF DECEASED	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF PHYSICIAN		18. SIGNATURE OF CLERK		19. SIGNATURE OF REGISTRAR		20. SIGNATURE OF WITNESSES	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13067

CERTIFICATE OF DEATH

Reg. Dist. No.

13066

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>205 1/2 E. Locust St.</u>				d. STREET ADDRESS <u>205 1/2 E. Locust St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Herman</u> Middle <u>Chatham</u> Last <u>Chatham</u>				4. DATE OF DEATH Month <u>11</u> Day <u>20</u> Year <u>19 58</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-22-1885</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Allen, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>							
13. FATHER'S NAME <u>Elijah Chatham</u>				14. MOTHER'S MAIDEN NAME <u>Arlena Stewart</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>Mrs. Lola Owens 301 Quincy St. Salisbury, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Years</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>7-28-58</u> , 19 <u> </u> , to <u>11-20-58</u> , 19 <u> </u> , that I last saw the deceased alive on <u>10-31-58</u> , 19 <u> </u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>407 Camden Ave.</u> DATE SIGNED <u>11-22-58</u> ACTUAL SIGNATURE <u>Earl L. Royer</u> M.D. PHYSICIAN'S NAME (Type) <u>Earl L. Royer, M.D.</u> <u>Salisbury, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-24-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Worcester County Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Holloway and Co.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 26 '58</u>			
ADDRESS <u>Salisbury, Md.</u>				24b. REGISTRAR'S SIGNATURE <u>Carlton S. Francis</u>			

CERTIFICATE OF DEATH

STATE OF NEW YORK

County of _____

City of _____

On the _____ day of _____

at _____

13068

CERTIFICATE OF DEATH

13067

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				c. LENGTH OF STAY IN 1b 2 mos. 20 da.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS 609 N. 36th Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Francis Middle Mae Last Chipman				4. DATE OF DEATH Month November Day 8 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 30, 1918	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unk.				10b. KIND OF BUSINESS OR INDUSTRY Unk.			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Charles Hosley				14. MOTHER'S MAIDEN NAME Foose			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Hospital Records - Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 422.1 IMMEDIATE CAUSE (a) <input checked="" type="checkbox"/> Arteriosclerotic Cardiovascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X <input checked="" type="checkbox"/> Diabetes Mellitus				INTERVAL BETWEEN ONSET AND DEATH Years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 8/19/58 , 19 58 , to 11/8 , 19 58 , that I last saw the deceased alive on 11/8 , 19 58 , and that death occurred at 6:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 11/8/58 ACTUAL SIGNATURE L. Maldre, M.D. M.D. Salisbury, Maryland PHYSICIAN'S NAME (Type) L. Maldre, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-11-58		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Towson, Inc. 1050 York Rd. Towson, Md.				24a. REC'D BY REGISTRAR NOV 10 58		24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13069

CERTIFICATE OF DEATH

13068

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 SALISBURY</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>82 PENINSULA GENERAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>IRVING</u> Last <u>COHEN</u>		4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>9</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 11, 1909</u>
9. AGE (In years low birthday) yrs. <u>48</u>		IF UNDER 1 YEAR Months <u>11</u> Days <u>28</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Radio Tech. & Repairman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>(Own Business)</u>	
11. BIRTHPLACE (State or foreign country) <u>Oklahoma</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>No Record</u>		14. MOTHER'S MAIDEN NAME <u>No Record</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>W.W. 11</u>	
17. INFORMANT <u>Mrs. Della S. Cohen (Wife)</u>		Address <u>300 Sheffield Ave Salisbury, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Atherosclerosis</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X Diabetes Mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 30, 1958</u> to <u>Nov. 9, 1958</u> , that I last saw the deceased alive on <u>Nov. 9, 1958</u> , and that death occurred at <u>2 A. M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Salisbury Md.</u> DATE SIGNED <u>Nov. 9, 1958</u>	
ACTUAL SIGNATURE <u>David J. Gilmore</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Dr. David J. Gilmore</u>		Medical Center, Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>Nov. 13, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>J. Wm Lee & Son Funeral Home - Washington D.C.</u>		22d. LOCATION (City, town, or county) (State) <u></u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u>		ADDRESS <u>SALISBURY MARYLAND</u>	
24a. REC'D BY REGISTRAR <u>NOV 12 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>	

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of coroner		11. Signature of jury		12. Signature of witnesses	
13. Signature of undertaker		14. Signature of funeral home		15. Signature of cemetery		16. Signature of church	
17. Signature of family		18. Signature of friends		19. Signature of neighbors		20. Signature of community	
21. Signature of school		22. Signature of employer		23. Signature of neighbors		24. Signature of community	
25. Signature of church		26. Signature of cemetery		27. Signature of funeral home		28. Signature of undertaker	
29. Signature of family		30. Signature of friends		31. Signature of neighbors		32. Signature of community	
33. Signature of school		34. Signature of employer		35. Signature of neighbors		36. Signature of community	
37. Signature of church		38. Signature of cemetery		39. Signature of funeral home		40. Signature of undertaker	
41. Signature of family		42. Signature of friends		43. Signature of neighbors		44. Signature of community	
45. Signature of school		46. Signature of employer		47. Signature of neighbors		48. Signature of community	
49. Signature of church		50. Signature of cemetery		51. Signature of funeral home		52. Signature of undertaker	
53. Signature of family		54. Signature of friends		55. Signature of neighbors		56. Signature of community	
57. Signature of school		58. Signature of employer		59. Signature of neighbors		60. Signature of community	
61. Signature of church		62. Signature of cemetery		63. Signature of funeral home		64. Signature of undertaker	
65. Signature of family		66. Signature of friends		67. Signature of neighbors		68. Signature of community	
69. Signature of school		70. Signature of employer		71. Signature of neighbors		72. Signature of community	
73. Signature of church		74. Signature of cemetery		75. Signature of funeral home		76. Signature of undertaker	
77. Signature of family		78. Signature of friends		79. Signature of neighbors		80. Signature of community	
81. Signature of school		82. Signature of employer		83. Signature of neighbors		84. Signature of community	
85. Signature of church		86. Signature of cemetery		87. Signature of funeral home		88. Signature of undertaker	
89. Signature of family		90. Signature of friends		91. Signature of neighbors		92. Signature of community	
93. Signature of school		94. Signature of employer		95. Signature of neighbors		96. Signature of community	
97. Signature of church		98. Signature of cemetery		99. Signature of funeral home		100. Signature of undertaker	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13119

CERTIFICATE OF DEATH

13069

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar				c. LENGTH OF STAY IN 1b 19 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION REF # 3				d. STREET ADDRESS REF # 3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ralph Thompson Coursey				4. DATE OF DEATH Month Nov. Day 15. Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 23, 1892	
9. AGE (In years last birthday) 66 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Street car		10b. KIND OF BUSINESS OR INDUSTRY Transportation		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Ralph T. Coursey			
14. MOTHER'S MAIDEN NAME Florence Covell				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I			
16. SOCIAL SECURITY NO. 215-2-2057				17. INFORMANT Beatrice Bratten, Delmar, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 7 minutes				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from 3/1, 1957 , to death , 19 58 , that I last saw the deceased alive on 11/7/58 , 19 58 , and that death occurred at 11:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE E M LARORE M.D.				ADDRESS (Street, city or town, state) 100 Grove St. DATE SIGNED 11/15/58			
PHYSICIAN'S NAME (Type) E M LARORE							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-19-58		22c. NAME OF CEMETERY OR CREMATORY Parsons		22d. LOCATION (City, town, or county) (State) Delmar, Delaware	
23. FUNERAL DIRECTOR'S SIGNATURE W-S Garrel Co - Delmar, Del				24a. REC'D BY REGISTRAR DATE NOV 20 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Hurd	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13070
CERTIFICATE OF DEATH

Reg. Dist. No.

13070

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 2 Mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springhill Sanitarium, Inc.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ocean City 23X-2	
3. NAME OF DECEASED (Type or print) First Middle Last HETTIE Mary Cropper		4. DATE OF DEATH Month Day Year Nov. 30, 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 20, 1880
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY RETIRED	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME LEMOUEL R. MELVIN		14. MOTHER'S MAIDEN NAME MARY BOWDEN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NO	
17. INFORMANT MRS. MABEL KEENE		Address OCEAN VIEW DEL.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarct, acute 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 30 minutes	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-5- , 1958 , to 11-30 , 1958 , that I last saw the deceased alive on 11-29 , 1958 , and that death occurred at 10:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Wilber R. Ellis, Jr.		M.D. Medical Center, Salisbury, Md.	
PHYSICIAN'S NAME (Type) Wilber R. Ellis, Jr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/3/58	
22c. NAME OF CEMETERY OR CREMATORY EVERGREEN		22d. LOCATION (City, town, or county) (State) Berlin Md	
23. FUNERAL DIRECTOR'S SIGNATURE Anna R. Burbage		ADDRESS Berlin Md	
24a. REC'D BY REGISTRAR DEC 3 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Keene	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13120
CERTIFICATE OF DEATH

13071

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Quantico R.F. D. 3 c. LENGTH OF STAY IN b. Home d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebron d. STREET ADDRESS R. F. D. # 3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Raymond Middle F. Last Dashield		4. DATE OF DEATH Month 11 Day 8 Year 19 58	
5. SEX male	6. COLOR OR RACE Col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/27/1899
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Frank Dashield		14. MOTHER'S MAIDEN NAME Angia Gosslee	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Margrette Dashield R.F. D. 3		Address Hebron Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) ?			INTERVAL BETWEEN ONSET AND DEATH 2 days Unknown Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Nov. 8, 19 58 to Nov. 8, 19 58 , that I last saw the deceased alive on Nov. 8, 19 58 , and that death occurred at 9:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 400 E. Church St. Salisbury Md DATE SIGNED Nov 15, 58			
ACTUAL SIGNATURE G. Herbert Sembly M.D.		DATE SIGNED Nov 15, 58	
PHYSICIAN'S NAME (Type) G. Herbert Sembly		Salisbury Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 11/16/ 58	22c. NAME OF CEMETERY OR CREMATORY Quantico	22d. LOCATION (City, town, or county) (State) Quantico Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Clinton O. Stuart		ADDRESS Salisbury Md	
24a. REC'D BY REGISTRAR NOV 20 '58		24b. REGISTRAR'S SIGNATURE Clinton O. Stuart	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13121

CERTIFICATE OF DEATH

13072

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Chesapeake</i> <i>Md</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Chesapeake</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Madella</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Madella</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>Addie</i> First <i>Deshull</i> Middle Last		4. DATE OF DEATH Month <i>Nov</i> Day <i>5</i> Year <i>1958</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 1885</i>
9. AGE (In years last birthday) <i>73</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	
11. BIRTHPLACE (State or foreign country) <i>Madella</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Irving Cleckley</i>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>219-07-7157</i>	
17. INFORMANT <i>Crawford Deshull</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.1</i> <i>degenerative heart disease</i> DUE TO (b) <i>arteriosclerosis</i> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <i>1 yr 4 mo. Indefinite</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>15 June</i> , 19 <i>51</i> , to <i>5 Nov</i> , 19 <i>58</i> that I last saw the deceased alive on <i>5 Nov</i> , 19 <i>58</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Purnell</i>		DATE SIGNED <i>7 Nov 58</i>	
PHYSICIAN'S NAME (Type) <i>E. A. PURNELL, M.D.</i>		ADDRESS (Street; city or town, state) <i>652 W. Main Salisbury, Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11-9-58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Madella</i>		22d. LOCATION (City, town, or county) (State) <i>Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur M. Ward</i> ADDRESS		24a. REC'D BY REGISTRAR <i>NOV 13 58</i> DATE	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>	

CERTIFICATE OF DEATH

1912

WILLIAM BROWN

WILLIAM BROWN

DATE OF DEATH

PLACE

PLACE OF DEATH

CAUSE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13071

CERTIFICATE OF DEATH

13073

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>12</u> <u>SALISBURY</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PELINUSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>1861 W. ISABELLA ST.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Doland</u> Middle <u>F</u> Last <u>DUNCAN</u>		4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>26</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOVEMBER 25, 1958</u>
9. AGE (In years last birthday) yrs. <u>15</u> Months <u>2</u> Days <u>28</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Doland F. Fletcher</u>		14. MOTHER'S MAIDEN NAME <u>Mary A. Duncan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mary A. Duncan</u>		Address <u>861 W. Isabella St. Salisbury Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cortical fetal atelectasis</u> 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral edema and congestion</u> DUE TO (c) <u>Fetal anoxia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 1/2 hrs</u> <u>15 1/2 hrs</u> <u>16 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prematurity</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/25/58</u> , 19 <u>58</u> , to <u>11/26/58</u> , that I last saw the deceased alive on <u>11/25/58</u> , 19 <u>58</u> , and that death occurred at <u>5:25 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. L. Sanders</u> M.D.		ADDRESS (Street, city or town, state) <u>707 Camden Ave Salisbury Md.</u>	
DATE SIGNED <u>11/26/58</u>			
PHYSICIAN'S NAME (Type) <u>Salisbury Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/28/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Winton F. Stewart</u>		ADDRESS <u>Salisbury Md.</u>	
24a. REC'D BY REGISTRAR <u>DEC 2 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>	

CERTIFICATE OF DEATH

STATE OF NEW YORK - BUREAU OF HEALTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

CHILDREN

PREVIOUS ILLNESS

DIAGNOSIS

TREATMENT

PROGNOSIS

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

CHILDREN

PREVIOUS ILLNESS

DIAGNOSIS

TREATMENT

PROGNOSIS

DATE OF DEATH

PLACE OF DEATH

13072

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>710 Rose Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Infant</u> First Middle Last				4. DATE OF DEATH <u>November 20</u> 19 <u>58</u> Month Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-18-58</u>	
9. AGE (In years last birthday) yrs. <u>2</u>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Salisbury Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Glenn Felton</u>				14. MOTHER'S MAIDEN NAME <u>Helen Ellis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Helen Ellis</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity (Birth wt 700 grams)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>776x</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 18</u> , 19 <u>58</u> , to <u>Nov 20</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov 20</u> , 19 <u>58</u> , and that death occurred at <u>5:00</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Alfred C. Koller</u>				ADDRESS (Street, city or town, state) <u>Medical Center</u>		DATE SIGNED <u>11/21/58</u>	
PHYSICIAN'S NAME (Type) <u>Salisbury Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-21-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Acres</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Brother M. West</u> ADDRESS				24a. REC'D BY REGISTRAR <u>DEC 15 '58</u>		24b. REGISTRAR'S SIGNATURE <u>William E. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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STATE DEPARTMENT OF HEALTH—BALTIMORE 18

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13073

CERTIFICATE OF DEATH

13074

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Accomack</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chincoteague, VA. 83X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>512 Willow St.</u>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Ewell</u> Last <u>Ewell</u>		4. DATE OF DEATH Month <u>November</u> Day <u>10</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 25, 1886</u>
9. AGE (In years - last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR: Months <u>78</u> Days <u>78</u> Hours <u>78</u> Min. <u>78</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>YARDMAN</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alfred Ewell</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Ann Taylor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>22705-7847</u>	
17. INFORMANT <u>Alice Ewell - Chincoteague, VA.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> <u>465X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Erythema Multiforme, Bullousum</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>9-30</u> , 19 <u>58</u> , to <u>11-10</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11-10</u> , 19 <u>58</u> , and that death occurred at <u>6:40 P.M.</u> from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>William R. Ellis, Jr.</u> M.D. <u>Salisbury, Md. 11-10-58</u>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-13-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Stockton</u>		22d. LOCATION (City, town, or county) (State) <u>Stockton Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton - New Church, VA.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>NOV 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thrush</u>	

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13074 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13075

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 12 Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 502 S. Division St		d. STREET ADDRESS 502 S. Division St	
3. NAME OF DECEASED (Type or print) WILLIAM First Middle Last		4. DATE OF DEATH Nov. 6th 1958 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 26, 1896
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR 0 Months 10 Days	11. IF UNDER 24 HRS. 0 Hours 10 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night Watchman		10b. KIND OF BUSINESS OR INDUSTRY North Carolina	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Kemp Fleenor		14. MOTHER'S MAIDEN NAME Belle Franklin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO. 11-3684-1111	
17. INFORMANT Mrs. Martha Ennis Adkins (Daughter)		R.D.# 2 Snow Hill, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 976X Gunshot wound of chest. DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH Sudden.			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self in chest.	
20c. TIME OF INJURY Month, Day, Year 2:25 P.M. 11-6-58		20d. INJURY OCCURRED Home	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Salisbury		20f. (City or town) (County) (State) Wicomico Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. Earl L. Royer		DATE SIGNED Nov. 7 /1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 9, 1958	
22c. NAME OF CEMETERY OR CREMATORY Wicomico Mem Park.		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR NOV 10 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

13075 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13076
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Wicomico</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1b <i>125</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>82 Peninsula General Hospital</i>		d. STREET ADDRESS <i>1404 East Church</i>	
3. NAME OF DECEASED (Type or print) First <i>Alice</i> Middle <i>Fletcher</i> Last <i>Fletcher</i>		4. DATE OF DEATH Month <i>November</i> Day <i>5</i> Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Colored</i>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>May 22, 1924</i>
9. AGE (In years last birthday) <i>34</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>34</i> Days <i>34</i> Hours <i>34</i> Min. <i>34</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Accomack County, Va</i>	
11. BIRTHPLACE (State or foreign country) <i>Accomack County, Va</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James Ed. Fletcher</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Stevens</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-22-862</i>	
17. INFORMANT <i>Bettie Stevens</i>		Address <i>Onancock, Va</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>442X</i> DUE TO <i>Cardiovascular renal disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>442X</i> DUE TO <i>442X</i> (c) <i>442X</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>11-5-</i> p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>10-18-</i> , 19 <i>58</i> , to <i>11-5-</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>11-5-</i> , 19 <i>58</i> , and that death occurred at <i>4:15</i> p. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Philip A. Insley</i>		ADDRESS (Street, city or town, state) <i>Salisbury, Md</i>	
PHYSICIAN'S NAME (Type) <i>Philip A. Insley</i>		DATE SIGNED <i>11-7-58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Nov. 10, 1958</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Joynes Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Onancock, Virginia</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jedgar Thomas</i>		ADDRESS <i>Accomack, Va</i>	
24a. REC'D BY REGISTRAR DATE <i>NOV 12 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Thomas</i>	

CERTIFICATE OF DEATH

<p>NAME OF DECEASED [Faint, illegible text]</p>		<p>AGE [Faint, illegible text]</p>	
<p>SEX [Faint, illegible text]</p>		<p>DATE OF DEATH [Faint, illegible text]</p>	
<p>PLACE OF BIRTH [Faint, illegible text]</p>		<p>PLACE OF DEATH [Faint, illegible text]</p>	
<p>CAUSE OF DEATH [Faint, illegible text]</p>		<p>DATE OF BURIAL [Faint, illegible text]</p>	
<p>NAME OF PHYSICIAN [Faint, illegible text]</p>		<p>NAME OF MINISTER OF THE GOSPEL [Faint, illegible text]</p>	
<p>NAME OF CORONER [Faint, illegible text]</p>		<p>NAME OF JURY [Faint, illegible text]</p>	
<p>NAME OF REGISTRAR [Faint, illegible text]</p>		<p>NAME OF CLERK [Faint, illegible text]</p>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A1SME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13076 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13077

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 1 Hr. 35 Mi d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY North Carolina c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Shallottle d. STREET ADDRESS 70X-3 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FIRST Alton Middle Henry Last Gales		4. DATE OF DEATH Month 11- Day 2- Year 19 58	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 15, 1936
9. AGE (In years last birthday) 22 yrs.		IF UNDER 1 YEAR Months 2 Days 2	IF UNDER 24 HRS. Hours 1 Min. 35
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	11. BIRTHPLACE (State or foreign country) N.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Dannie W. Gales	
14. MOTHER'S MAIDEN NAME Elvie Blanton		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 237-54-0831		17. INFORMANT Mr. Dannie Gales, Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed chest 825X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Driver of car in accident on R F D # 13 near Pocomoke		INTERVAL BETWEEN ONSET AND DEATH 1 Hr. 35 min.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 11:25 P.M. 11-1-58		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) R F D # 13		20f. (City or town) (County) (State) Pocomoke Worcester Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Earl L. Royer, M.D.		DATE SIGNED 11-2-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/5/58	
22c. NAME OF CEMETERY OR CREMATORY Chapel Hill		22d. LOCATION (City, town, or county) (State) Shallottle, N.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Maryland Norman D. Baker		24a. REC'D BY REGISTRAR DATE NOV 5 '58	
24b. REGISTRAR'S SIGNATURE Arthur L. Thana			

STATE OF
HEALTH DEPT.

1907

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

1. Name of deceased: _____

2. Age: _____

3. Sex: _____

4. Date of death: _____

5. Place of death: _____

6. Cause of death: _____

7. Signature of Medical Examiner: _____

8. Date of certificate: _____

9. Name of attending physician: _____

10. Name of informant: _____

11. Name of funeral home: _____

12. Name of cemetery: _____

13. Name of burial place: _____

14. Name of next of kin: _____

15. Name of executor: _____

16. Name of administrator: _____

17. Name of guardian: _____

18. Name of trustee: _____

19. Name of beneficiary: _____

20. Name of heir: _____

21. Name of legatee: _____

22. Name of devisee: _____

23. Name of assignee: _____

24. Name of transferee: _____

25. Name of mortgagee: _____

26. Name of pledgee: _____

27. Name of vendee: _____

28. Name of purchaser: _____

29. Name of grantee: _____

30. Name of donee: _____

31. Name of tenant: _____

32. Name of landlord: _____

33. Name of lessor: _____

34. Name of lessee: _____

35. Name of contractor: _____

36. Name of subcontractor: _____

37. Name of supplier: _____

38. Name of distributor: _____

39. Name of retailer: _____

40. Name of wholesaler: _____

41. Name of importer: _____

42. Name of exporter: _____

43. Name of manufacturer: _____

44. Name of producer: _____

45. Name of creator: _____

46. Name of inventor: _____

47. Name of discoverer: _____

48. Name of finder: _____

49. Name of finder of lost property: _____

50. Name of finder of treasure: _____

51. Name of finder of treasure trove: _____

52. Name of finder of treasure trove: _____

53. Name of finder of treasure trove: _____

54. Name of finder of treasure trove: _____

55. Name of finder of treasure trove: _____

56. Name of finder of treasure trove: _____

57. Name of finder of treasure trove: _____

58. Name of finder of treasure trove: _____

59. Name of finder of treasure trove: _____

60. Name of finder of treasure trove: _____

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78. Name of finder of treasure trove: _____

79. Name of finder of treasure trove: _____

80. Name of finder of treasure trove: _____

81. Name of finder of treasure trove: _____

82. Name of finder of treasure trove: _____

83. Name of finder of treasure trove: _____

84. Name of finder of treasure trove: _____

85. Name of finder of treasure trove: _____

86. Name of finder of treasure trove: _____

87. Name of finder of treasure trove: _____

88. Name of finder of treasure trove: _____

89. Name of finder of treasure trove: _____

90. Name of finder of treasure trove: _____

91. Name of finder of treasure trove: _____

92. Name of finder of treasure trove: _____

93. Name of finder of treasure trove: _____

94. Name of finder of treasure trove: _____

95. Name of finder of treasure trove: _____

96. Name of finder of treasure trove: _____

97. Name of finder of treasure trove: _____

98. Name of finder of treasure trove: _____

99. Name of finder of treasure trove: _____

100. Name of finder of treasure trove: _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13077

CERTIFICATE OF DEATH

13078

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown, Maryland 1437.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		d. STREET ADDRESS 211 Calvert St.	
3. NAME OF DECEASED (Type or print) First Gracie Middle A Last Graves		4. DATE OF DEATH Month Nov. Day 27 Year 19 58	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 4, 1889
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unk		10b. KIND OF BUSINESS OR INDUSTRY unk	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Ed. Smith	
14. MOTHER'S MAIDEN NAME Octavia Smith		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unk	
16. SOCIAL SECURITY NO. none		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic cardiovascular disease DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old Cerebral Hemorrhage			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov. 20 , 19 58 , to Nov. 27 , 19 58 , that I last saw the deceased alive on Nov. 27 , 19 58 , and that death occurred at 4:15 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE L. Maldve, M.D.		ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 11/27/58	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 30, 1958	22c. NAME OF CEMETERY OR CREMATORY Bigwoods Cem. near Worton, Md.	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth walby Chestertown, Md.		24a. REC'D BY REGISTRAR DATE DEC 1 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Frank

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTY OF BIRTH		STATE OF BIRTH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		PROGNOSIS		HISTORY		FAMILY HISTORY		SOCIAL HISTORY		OCCUPATION		EDUCATION		RELIGION	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JUDGE		SIGNATURE OF CLERK		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF SURVIVOR		SIGNATURE OF BURIAL		SIGNATURE OF CREMATION		SIGNATURE OF INTERMENT		SIGNATURE OF RECORD	

THIS CERTIFICATE IS A PUBLIC RECORD AND IS NOT TO BE DESTROYED OR REPRODUCED IN ANY MANNER WITHOUT THE WRITTEN PERMISSION OF THE STATE DEPARTMENT OF HEALTH.

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 19x-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS 88 Hampton Ave.	
3. NAME OF DECEASED (Type or print) First Hector Middle Hayward Last 		4. DATE OF DEATH Month 11- Day 22- Year 58	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 2, 1957
9. AGE (In years last birthday) 1 yrs.		IF UNDER 1 YEAR Months 5 Days Hours Min. 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Md. U S A
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Thomas Hayward	
14. MOTHER'S MAIDEN NAME Caroline		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mother: Caroline Hayward, P.A. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute congestive heart failure DUE TO (c) Sickle cell anemia			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3 hrs. 3 hours. Months.			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer		DATE SIGNED 11-27-58	
EXAMINER'S NAME (Type) Earl L. Royer, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 11/25/58	22c. NAME OF CEMETERY OR CREMATORY St Mark	22d. LOCATION (City, town, or county) (State) Salemville Md
23. FUNERAL DIRECTOR'S SIGNATURE William H. Jones Jr. Princess Anne		24a. REC'D BY REGISTRAR DEC 2 '58 24b. REGISTRAR'S SIGNATURE Arthur S. Krouse	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13079

CERTIFICATE OF DEATH

Reg. Dist. No. 13080

1. PLACE OF DEATH o. COUNTY <u>WICOMICO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>DELAWARE</u> b. COUNTY <u>SUSSEX</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>2 WKS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>82 PENINSULA General Hospital</u>		d. STREET ADDRESS <u>MILLSBORO 46X-3</u>	
3. NAME OF DECEASED (Type or print) First <u>Jerome</u> Middle <u>Henry</u> Last <u>Henry</u>		4. DATE OF DEATH Month <u>November</u> Day <u>19</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 27, 1904</u>
9. AGE (In years last birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>54</u> Days <u>54</u> Hours <u>54</u> Min. <u>54</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Poultry Plant</u>	
11. BIRTHPLACE (State or foreign country) <u>PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Jerome Henry</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Alexandra</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>174-01-061</u>	
17. INFORMANT <u>Clarissa Henry</u>		Address <u>MILLSBORO DEL.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>WIDESPREAD METASTATIC CARCINOMA</u> DUE TO <u>163X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CARCINOMA - LUNG - RT.</u> DUE TO <u>?</u> (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>6 WKS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____ and that death occurred at <u>8:25</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. Gray Rous</u>		ADDRESS (Street, city or town, state) <u>Medical Center Bldg - 19 Nov 1958</u>	
PHYSICIAN'S NAME (Type) <u>Salisbury, Maryland</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/23/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>HARMONY CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MILLSBORO - DEL.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ronald James Millsboro, Del.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>NOV 26 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13080

CERTIFICATE OF DEATH

Reg. Dist. No. 13081

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b Two Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown 14372	
3. NAME OF DECEASED (Type or print) First Morris Middle --- Last Hollins		4. DATE OF DEATH Month November Day 22 Year 1958	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 5, 1890
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Unk.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Hollins		14. MOTHER'S MAIDEN NAME Unk.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. YES Unk.	
17. INFORMANT Hospital Records - Salisbury, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH Unk.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/20 , 19 58 , to 11/22 , 19 58 , that I last saw the deceased alive on 11/22 , 19 58 , and that death occurred at 7:10 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 11/22/58 ACTUAL SIGNATURE L. V. Maldve M.D. PHYSICIAN'S NAME (Type) L. V. Maldve, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/26/58	
22c. NAME OF CEMETERY OR CREMATORY Janes Cemetery		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Wally		24. REC'D BY REGISTRAR DATE NOV 25 '58	
ADDRESS Chestertown, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1992

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13122

CERTIFICATE OF DEATH

Reg. Dist. No.

13082

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar				c. LENGTH OF STAY IN IB 35 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 906 State Street				e. STREET ADDRESS 906 State Street			
3. NAME OF DECEASED (Type or print) First Middle Last Amy Wilson Horsey				4. DATE OF DEATH Month Day Year Nov. 5, 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 20, 1894	
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Frank Wheatley			
14. MOTHER'S MAIDEN NAME Tamsey Williams				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No			
16. SOCIAL SECURITY NO. None				17. INFORMANT Address Andrew N. Horsey, Delmar, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral failure DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) Arteriosclerotic Heart Disease				INTERVAL BETWEEN ONSET AND DEATH 2 mos			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X Diabetes mellitus				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from 8/2 , 19 58 , to death , 19 58 , that I last saw the deceased alive on 11/5 , 19 58 , and that death occurred at 2 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE E. M. LARMORE M.D.				ADDRESS (Street, city or town, state) DATE SIGNED 100 Crest Delmar, Del. 11/6/58			
PHYSICIAN'S NAME (Type) E. M. LARMORE				DELMAR, DEL.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-8-58		22c. NAME OF CEMETERY OR CREMATORY Mt. Olive		22d. LOCATION (City, town, or county) (State) Delmar, Del.	
23. FUNERAL DIRECTOR'S SIGNATURE H. S. Marvel Co - Delmar, Del.				ADDRESS Delmar, Del.		24a. REC'D BY REGISTRAR DATE NOV 10 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Frank							

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13123

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13083

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bivalve		c. LENGTH OF STAY IN 1b X		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bivalve	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Jesse Middle B Last Insley			4. DATE OF DEATH Month 11- Day 6- Year 19 58		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-8-1901		9. AGE (In years last birthday) 57 yrs. 2 Months 28 Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Robert L. Insley			12. CITIZEN OF WHAT COUNTRY? U S A		
14. MOTHER'S MAIDEN NAME Mary Louisa ?			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. -----		17. INFORMANT William R. Insley Bivalve, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of chest. 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Sudden					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self in chest with sawed off shot gun.			
20c. TIME OF INJURY Month, Day, Year 4 P.M. 11-6-58	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home-yard.		20f. (City or town) (County) (State) Bivalve Wicomico Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Earl L. Royer, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 11-7-58			
EXAMINER'S NAME (Type) Earl L. Royer, M.D.		DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-9-58		22c. NAME OF CEMETERY OR CREMATORY Bivalve Cemetery	
22d. LOCATION (City, town, or county) (State) Bivalve Md.		23. FUNERAL DIRECTOR'S SIGNATURE Ed M. Messitt, Bivalve, Maryland			
24a. REC'D BY REGISTRAR NOV 14 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Evans			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13081

CERTIFICATE OF DEATH

Reg. Dist. No.

13084

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DELEWARE</u> b. COUNTY <u>SUSSEX</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u> 46X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>LAUREL-JEFFORD Highway</u>			
3. NAME OF DECEASED (Type or print) First <u>OSCAR</u> Middle <u>C</u> Last <u>JAMES</u>				4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>2</u> Year <u>1958</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Feb 17, 1889</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u>+</u> Days <u>+</u> Hours <u>+</u> Min <u>+</u>		IF UNDER 24 HRS. Months <u>+</u> Days <u>+</u> Hours <u>+</u> Min <u>+</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nursery Owner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retail Plants</u>		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>	
13. FATHER'S NAME <u>BRANSTON James</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE ROGERS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>821-26-1505</u>			
				17. INFORMANT <u>MARION DeHAINNOUT</u> Address <u>SEAFORD RD Del.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct, acute</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>2 days</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>OCTOBER 31, 1958</u> , to <u>NOVEMBER 2, 1958</u> , that I last saw the deceased alive on <u>NOVEMBER 1, 1958</u> , and that death occurred at <u>12:01 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William R. Ellis</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>11-2-58</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/5/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ODD Fellows Cem</u>		22d. LOCATION (City, town, or county) (State) <u>LAUREL Del</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Johnson</u> ADDRESS <u>Seaford Del.</u>				24a. RECEIVED BY REGISTRAR <u>NOV 5 '58</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

CERTIFICATE OF DEATH

WILLIAM H. BROWN
MAY 18 1901
AGE 65

WILLIAM H. BROWN
MAY 18 1901
AGE 65

WILLIAM H. BROWN
MAY 18 1901
AGE 65

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13082 CERTIFICATE OF DEATH

13085

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 18 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Faulkner		08X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		d. STREET ADDRESS --	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Laura Middle -- Last Jordan		4. DATE OF DEATH Month November Day 14 Year 19 58	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 12, 1886
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jackson		14. MOTHER'S MAIDEN NAME Anna Jackson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. --	
17. INFORMANT Hospital Records, Salisbury, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial insufficiency 715X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260X (b) Septicemia DUE TO (c) Multiple decubiti INTERVAL BETWEEN ONSET AND DEATH 12 hours 4 days Weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) General Arteriosclerosis, Left Hemiplegia, Diabetes Mellitus			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 27, 19 58 to Nov. 14, 19 58 , that I last saw the deceased alive on Nov. 14, 19 58 , and that death occurred at 8:00P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 11/14/58			
ACTUAL SIGNATURE G. Kosmahly		M.D. Salisbury, Maryland	
PHYSICIAN'S NAME (Type) G. Kosmahly, M.D.		Deer's Head State Hospital	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/22/58	22c. NAME OF CEMETERY OR CREMATORY Shilo M.E.	22d. LOCATION (City, town, or county) (State) Shilo Md.
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Md.		24a. REC'D BY REGISTRAR Nov 25 '58	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

Page 2011-2012

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>		<p>3. AGE [Faint text]</p>		<p>4. DATE OF BIRTH [Faint text]</p>		<p>5. PLACE OF BIRTH [Faint text]</p>	
<p>6. DATE OF DEATH [Faint text]</p>		<p>7. TIME OF DEATH [Faint text]</p>		<p>8. PLACE OF DEATH [Faint text]</p>		<p>9. CAUSE OF DEATH [Faint text]</p>		<p>10. MANNER OF DEATH [Faint text]</p>	
<p>11. SIGNATURE OF DECEASED [Faint text]</p>		<p>12. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>13. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>14. SIGNATURE OF REGISTRAR [Faint text]</p>		<p>15. SIGNATURE OF CLERK [Faint text]</p>	
<p>16. SIGNATURE OF DECEASED [Faint text]</p>		<p>17. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>18. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>19. SIGNATURE OF REGISTRAR [Faint text]</p>		<p>20. SIGNATURE OF CLERK [Faint text]</p>	
<p>21. SIGNATURE OF DECEASED [Faint text]</p>		<p>22. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>23. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>24. SIGNATURE OF REGISTRAR [Faint text]</p>		<p>25. SIGNATURE OF CLERK [Faint text]</p>	
<p>26. SIGNATURE OF DECEASED [Faint text]</p>		<p>27. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>28. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>29. SIGNATURE OF REGISTRAR [Faint text]</p>		<p>30. SIGNATURE OF CLERK [Faint text]</p>	
<p>31. SIGNATURE OF DECEASED [Faint text]</p>		<p>32. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>33. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>34. SIGNATURE OF REGISTRAR [Faint text]</p>		<p>35. SIGNATURE OF CLERK [Faint text]</p>	
<p>36. SIGNATURE OF DECEASED [Faint text]</p>		<p>37. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>38. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>39. SIGNATURE OF REGISTRAR [Faint text]</p>		<p>40. SIGNATURE OF CLERK [Faint text]</p>	
<p>41. SIGNATURE OF DECEASED [Faint text]</p>		<p>42. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>43. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>44. SIGNATURE OF REGISTRAR [Faint text]</p>		<p>45. SIGNATURE OF CLERK [Faint text]</p>	
<p>46. SIGNATURE OF DECEASED [Faint text]</p>		<p>47. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>48. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>49. SIGNATURE OF REGISTRAR [Faint text]</p>		<p>50. SIGNATURE OF CLERK [Faint text]</p>	
<p>51. SIGNATURE OF DECEASED [Faint text]</p>		<p>52. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>53. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>54. SIGNATURE OF REGISTRAR [Faint text]</p>		<p>55. SIGNATURE OF CLERK [Faint text]</p>	
<p>56. SIGNATURE OF DECEASED [Faint text]</p>		<p>57. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>58. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>59. SIGNATURE OF REGISTRAR [Faint text]</p>		<p>60. SIGNATURE OF CLERK [Faint text]</p>	
<p>61. SIGNATURE OF DECEASED [Faint text]</p>		<p>62. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>63. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>64. SIGNATURE OF REGISTRAR [Faint text]</p>		<p>65. SIGNATURE OF CLERK [Faint text]</p>	
<p>66. SIGNATURE OF DECEASED [Faint text]</p>		<p>67. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>68. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>69. SIGNATURE OF REGISTRAR [Faint text]</p>		<p>70. SIGNATURE OF CLERK [Faint text]</p>	
<p>71. SIGNATURE OF DECEASED [Faint text]</p>		<p>72. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>73. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>74. SIGNATURE OF REGISTRAR [Faint text]</p>		<p>75. SIGNATURE OF CLERK [Faint text]</p>	
<p>76. SIGNATURE OF DECEASED [Faint text]</p>		<p>77. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>78. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>79. SIGNATURE OF REGISTRAR [Faint text]</p>		<p>80. SIGNATURE OF CLERK [Faint text]</p>	
<p>81. SIGNATURE OF DECEASED [Faint text]</p>		<p>82. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>83. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>84. SIGNATURE OF REGISTRAR [Faint text]</p>		<p>85. SIGNATURE OF CLERK [Faint text]</p>	
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<p>91. SIGNATURE OF DECEASED [Faint text]</p>		<p>92. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>93. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>94. SIGNATURE OF REGISTRAR [Faint text]</p>		<p>95. SIGNATURE OF CLERK [Faint text]</p>	
<p>96. SIGNATURE OF DECEASED [Faint text]</p>		<p>97. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>98. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>99. SIGNATURE OF REGISTRAR [Faint text]</p>		<p>100. SIGNATURE OF CLERK [Faint text]</p>	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MASSACHUSETTS DEPARTMENT OF HEALTH - BIRTH-DEATH REGISTRY



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13083

CERTIFICATE OF DEATH

13086

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>14 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>RUDOLPH</u> Last <u>Kelly</u>		4. DATE OF DEATH Month <u>November</u> Day <u>30</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 20, 1889</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brick Mason (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>- - - John - - - Kelly</u>		14. MOTHER'S MAIDEN NAME <u>Annie Yow</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Unk</u>		16. SOCIAL SECURITY NO. <u>17. INFORMANT <u>Mrs. Beatrice M. Kelly (wife) 302 E. Locust St. Salisbury, Maryland</u></u>	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Disease</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x10 Diabetes Mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>16 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/14</u> , 19 <u>58</u> , to <u>11/30</u> , 19 <u>58</u> , that I lost s/he the deceased alive on <u>11/29</u> , 19 <u>58</u> , and that death occurred at <u>8:15 A.M.</u> from the causes and on the date stated above		ADDRESS (Street, city or town, state) <u>Blue Bluff Road</u> DATE SIGNED <u>11/30/58</u>	
ACTUAL SIGNATURE <u>Thomas C. Hill Jr.</u> M.D.		PHYSICIAN'S NAME (Type) <u>Dr. Thomas C. Hill Jr.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 4, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Couldree Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Moore County - N. Carolina</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u> ADDRESS <u>SALISBURY MARYLAND</u>		24a. REC'D BY REGISTRAR <u>DEC 2 '58</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

CERTIFICATE OF DEATH

<p>1. Name of deceased</p>		<p>2. Sex</p>		<p>3. Age</p>		<p>4. Date of death</p>	
<p>5. Place of death</p>		<p>6. Cause of death</p>		<p>7. Manner of death</p>		<p>8. Signature of physician</p>	
<p>9. Signature of registrar</p>		<p>10. Signature of witness</p>		<p>11. Signature of witness</p>		<p>12. Signature of witness</p>	
<p>13. Signature of witness</p>		<p>14. Signature of witness</p>		<p>15. Signature of witness</p>		<p>16. Signature of witness</p>	
<p>17. Signature of witness</p>		<p>18. Signature of witness</p>		<p>19. Signature of witness</p>		<p>20. Signature of witness</p>	
<p>21. Signature of witness</p>		<p>22. Signature of witness</p>		<p>23. Signature of witness</p>		<p>24. Signature of witness</p>	
<p>25. Signature of witness</p>		<p>26. Signature of witness</p>		<p>27. Signature of witness</p>		<p>28. Signature of witness</p>	
<p>29. Signature of witness</p>		<p>30. Signature of witness</p>		<p>31. Signature of witness</p>		<p>32. Signature of witness</p>	
<p>33. Signature of witness</p>		<p>34. Signature of witness</p>		<p>35. Signature of witness</p>		<p>36. Signature of witness</p>	
<p>37. Signature of witness</p>		<p>38. Signature of witness</p>		<p>39. Signature of witness</p>		<p>40. Signature of witness</p>	
<p>41. Signature of witness</p>		<p>42. Signature of witness</p>		<p>43. Signature of witness</p>		<p>44. Signature of witness</p>	
<p>45. Signature of witness</p>		<p>46. Signature of witness</p>		<p>47. Signature of witness</p>		<p>48. Signature of witness</p>	
<p>49. Signature of witness</p>		<p>50. Signature of witness</p>		<p>51. Signature of witness</p>		<p>52. Signature of witness</p>	
<p>53. Signature of witness</p>		<p>54. Signature of witness</p>		<p>55. Signature of witness</p>		<p>56. Signature of witness</p>	
<p>57. Signature of witness</p>		<p>58. Signature of witness</p>		<p>59. Signature of witness</p>		<p>60. Signature of witness</p>	
<p>61. Signature of witness</p>		<p>62. Signature of witness</p>		<p>63. Signature of witness</p>		<p>64. Signature of witness</p>	
<p>65. Signature of witness</p>		<p>66. Signature of witness</p>		<p>67. Signature of witness</p>		<p>68. Signature of witness</p>	
<p>69. Signature of witness</p>		<p>70. Signature of witness</p>		<p>71. Signature of witness</p>		<p>72. Signature of witness</p>	
<p>73. Signature of witness</p>		<p>74. Signature of witness</p>		<p>75. Signature of witness</p>		<p>76. Signature of witness</p>	
<p>77. Signature of witness</p>		<p>78. Signature of witness</p>		<p>79. Signature of witness</p>		<p>80. Signature of witness</p>	
<p>81. Signature of witness</p>		<p>82. Signature of witness</p>		<p>83. Signature of witness</p>		<p>84. Signature of witness</p>	
<p>85. Signature of witness</p>		<p>86. Signature of witness</p>		<p>87. Signature of witness</p>		<p>88. Signature of witness</p>	
<p>89. Signature of witness</p>		<p>90. Signature of witness</p>		<p>91. Signature of witness</p>		<p>92. Signature of witness</p>	
<p>93. Signature of witness</p>		<p>94. Signature of witness</p>		<p>95. Signature of witness</p>		<p>96. Signature of witness</p>	
<p>97. Signature of witness</p>		<p>98. Signature of witness</p>		<p>99. Signature of witness</p>		<p>100. Signature of witness</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13124 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13087

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebron		c. LENGTH OF STAY IN 1b X Hebron		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebron	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Marvil Packing Co. Hebron, Md.			d. STREET ADDRESS Church		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Edward Middle Lake Last Kimney			4. DATE OF DEATH Month 11 Day 26 Year 19 58		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 18, 1906		9. AGE (In years last birthday) 52 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY Package making		11. BIRTHPLACE (State or foreign country) Secretary, Md.	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Benjamin Kimney		
14. MOTHER'S MAIDEN NAME Emma Short			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		
16. SOCIAL SECURITY NO. *****		17. INFORMANT Address 213-03-4697 Minnie Kimney, Hebron, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Hebron	(County) Wicomico	(State) Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Earl L. Royer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 11-27-58	
EXAMINER'S NAME (Type) Earl L. Royer, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-29-58	22c. NAME OF CEMETERY OR CREMATORY Firemans	22d. LOCATION (City, town, or county) Sharptown, Md.	(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles H. Garrel, Sharptown, Md.		ADDRESS Sharptown, Md.		24a. REC'D BY REGISTRAR DEC 1 '58	24b. REGISTRAR'S SIGNATURE Calvin E. Lewis

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

13125

CERTIFICATE OF DEATH

Reg. Dist. No.

13089

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# 1				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) WILLIAM McKINLEY KNOWLES				4. DATE OF DEATH NOV. 28th 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 3, 1904	
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR 4 Months 25 Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Bus Operator				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Riverton, Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Rufus D. Knowles				14. MOTHER'S MAIDEN NAME Melissa Hearn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Eleanor C. Knowles (Wife) R.D.# 1 Mardela, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Vasculomegaly cerebral arterioles DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Renal ischemia and pulmonary arteriole sclerosis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 11/20 , 19 58 , to death , 19 58 , that I last saw the deceased alive on 11/28 , 19 58 , and that death occurred at 9:25 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Ernest M. Larmore				ADDRESS (Street, city or town, state) 1006 West St. Delmar, Del. DATE SIGNED Nov. 30 / 1958			
PHYSICIAN'S NAME (Type) Dr. Ernest M. Larmore				Delmar, Delaware			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 1, 1958		22c. NAME OF CEMETERY OR CREMATORY Riverton Church Cemetery		22d. LOCATION (City, town, or county) (State) Riverton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR DEC 3 '58 24b. REGISTRAR'S SIGNATURE Arthur S. Kraw	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the City Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: This certificate should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13084 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13090

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pen Gen. Hospital			d. STREET ADDRESS 515 S. Pinehurst Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First RUTH Middle Li Last Tow			4. DATE OF DEATH Month 11 Day 9 Year 1958		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 7, 1905	9. AGE (In years last birthday) 53 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (State or foreign country) Philadelphia Pa	
13. FATHER'S NAME Morris - - - - -			14. MOTHER'S MAIDEN NAME No Record		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Leon Goldstein Address 5625 Woodcrest Ave. Phila. Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None					INTERVAL BETWEEN ONSET AND DEATH 3 min
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , <u>Inspection</u> <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE Philip A. Insley		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 11-9-58	
EXAMINER'S NAME (Type) Philip A. Insley		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 10, 1958		22c. NAME OF CEMETERY OR CREMATORY Roosevelt Cemetery	
22d. LOCATION (City, town, or county) Philadelphia. Pa. (Bucks Co.)		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR NOV 13 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13085 CERTIFICATE OF DEATH

13088

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>817 Cooper St.</u>	
3. NAME OF DECEASED (Type or print) <u>James Daniel Mac Knight</u>		4. DATE OF DEATH Month <u>November</u> Day <u>19</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 19, 1958</u>
9. AGE (In years last birthday) yrs. <u>5</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>5</u> Hours <u>5</u> Min. <u>5</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Salisbury, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Raymond Louis Mac Knight</u>		14. MOTHER'S MAIDEN NAME <u>Cecilia Sharpe</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Mr. Raymond L. Mac Knight (Father)</u> <u>817. Cooper St. Salisbury, Maryland.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracranial hemorrhage</u> <u>761.5</u> DUE TO <u>Anoxia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Excessive bleeding Placenta Previa</u> (c) <u>Prematurity (28 wk pregnancy)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 hour</u> <u>1 hour</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>11/19/58</u> to <u>11/19/58</u> , that I last saw the deceased alive on <u>11/19/58</u> , and that death occurred at <u>9:45 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>211 Maryland Ave. Salisbury, Md.</u> DATE SIGNED <u>11-21-58</u> ACTUAL SIGNATURE <u>Dr. J. J. Burton</u> M.D. PHYSICIAN'S NAME (Type) <u>211 Maryland Ave. Salisbury, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL <u>Burial</u>		22b. DATE THEREOF <u>Nov. 20. 58.</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Mem. Park.</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Holloway & Co.</u>		ADDRESS <u>Salisbury, Maryland</u>	
24a. REC'D BY REGISTRAR <u>NOV 24 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2082221XVI

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13086 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13091

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>2 weeks</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springhill Sanitarium</u>		d. STREET ADDRESS <u>Route 2 Berlin</u>	
3. NAME OF DECEASED (Type or print) <u>Algia</u> <u>Reginald</u> <u>Mariner</u>		4. DATE OF DEATH Month <u>11</u> Day <u>24</u> Year <u>19 58</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-6-1883</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	
11. BIRTHPLACE (State or foreign country) <u>Snow Hill, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edwin A. Mariner</u>		14. MOTHER'S MAIDEN NAME <u>Suzan Holland</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Reginald Mariner, Berlin, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sub dural hematoma, left.</u> 902.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Accidental fall</u> DUE TO (c) <u>Accidental fall</u> INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>7 das.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterio-sclerotic cardio-vascular disease</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DECEASED HAD INJURY OCCURRED (State of injury) <u>Patient was confused and required restraints, yet on 11-18-58 got out of restraints and over side & fell on head.</u>	
20c. TIME OF INJURY Month, Day, Year <u>2-4 P.M. 11-18-58</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Nursing Home</u>	20f. (City or town) (County) <u>Salisbury Wicomico Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/26/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Zerbe</u>		ADDRESS <u>Berlin Md</u>	
24a. REC'D BY REGISTRAR <u>DATE</u>		24b. REGISTRAR'S SIGNATURE	

Film G237 - 1/15/59 - Originally this death was filed
on a regular death certificate form, but later found
to be a medical examiner's, so this certificate was
filed. mb

CERTIFICATE OF DEATH

1904

Page One

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>		<p>5. PLACE OF BIRTH</p>	
<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. PLACE OF DEATH</p>		<p>9. DATE OF DEATH</p>		<p>10. TIME OF DEATH</p>	
<p>11. SIGNATURE OF DECEASED</p>		<p>12. SIGNATURE OF WITNESSES</p>		<p>13. SIGNATURE OF PHYSICIAN</p>		<p>14. SIGNATURE OF CLERK</p>		<p>15. SIGNATURE OF JUDGE</p>	
<p>16. SIGNATURE OF CORONER</p>		<p>17. SIGNATURE OF SHERIFF</p>		<p>18. SIGNATURE OF TOWNSHIP CLERK</p>		<p>19. SIGNATURE OF COUNTY CLERK</p>		<p>20. SIGNATURE OF STATE CLERK</p>	

13088

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>DELAWARE</u> b. COUNTY <u>SUSSEX</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>10 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CLARENCE H. Matthews</u>		4. DATE OF DEATH <u>November 9, 1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-13-1879</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CAR INSPECTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>	
11. BIRTHPLACE (State or foreign country) <u>DELAWARE</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry C Matthews</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Jolly</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>716-01-9440</u>	
17. INFORMANT <u>Agnes Matthews, Delmar Del</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coronary thrombosis, acute</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>benign prostatic hypertrophy</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>10 years</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 26, 1958</u> , to <u>Nov. 9, 1958</u> , that I last saw the deceased alive on <u>Nov. 9, 1958</u> , and that death occurred at <u>11 A.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Raymond M. Yow</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>707 Camden Ave. Salisbury MD 11/9/58</u>	
PHYSICIAN'S NAME (Type) <u>Raymond M. Yow, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-12-58</u>	
22c. NAME OF CEMETERY OR CREMATOR <u>St. Mary's</u>		22d. LOCATION (City, town, or county) (State) <u>Delmar Del.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. Maml Co - Delmar Del.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>Nov 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1922

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES M. BOND		M		45		JAN 1 1877		NEW YORK	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
NEW YORK		CLOCK REPAIRER		HEART DISEASE		NATURAL		NEW YORK	
DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH		SECOND OF DEATH	
JAN 15 1922		10 30 AM		10		30		00	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR	
DATE OF REGISTRATION		TIME OF REGISTRATION		HOUR OF REGISTRATION		MINUTE OF REGISTRATION		SECOND OF REGISTRATION	
JAN 15 1922		10 30 AM		10		30		00	

CERTIFICATE OF DEATH

Reg. Dist. No.

13094

13089

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 12 Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen. Hospital				e. STREET ADDRESS 315 Park Ave			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)		First DELLA Middle FLORENCE Last McDANIEL		4. DATE OF DEATH		Month NOV. Day 10th Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 31, 1876		9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Worcester Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William Jones				14. MOTHER'S MAIDEN NAME Ada Fleming			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Rebecca Wolfe (Grand-Daughter) 403 Venton Place Salisbury, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema 422.1 DUE TO Acute Cardiac failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Atherosclerotic C-V Disease (c)							INTERVAL BETWEEN ONSET AND DEATH 0-10 hrs ? ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from 10/10, 1958 , to 10/10, 1958 , that I last saw the deceased alive on 10/10, 1958 , and that death occurred at 10:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Nov. 12/1958 DATE SIGNED							
ACTUAL SIGNATURE William D. Gray		M.D. Nov. 12/1958					
PHYSICIAN'S NAME (Type) Dr. William D. Gray 334 Camden Ave. Salisbury, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 13th, 1958	22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND				24a. REC'D BY REGISTRAR NOV 13 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Knaus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

13095

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fruitland				c. LENGTH OF STAY IN 1b 1 Hr.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION S. Division				e. STREET ADDRESS Pine Bluff Rd.,			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last James Morris McGrath				4. DATE OF DEATH Month Day Year 11 3 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 29, 1903		9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Vice Pres. & Treas. Electric Co.		10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Josiha V. McGrath				14. MOTHER'S MAIDEN NAME Mary Hastings			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 214-10-6478		17. INFORMANT Mrs. J.M. McGrath, Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct, acute DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 5 minutes						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-3 , 19 58 , to 11-3 , 19 58 that I last saw the deceased alive on 11-3 , 19 58 , and that death occurred at 5:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 11/4/58							
ACTUAL SIGNATURE Willen R. Ellis		M.D. Salisbury, Maryland					
PHYSICIAN'S NAME (Type) Dr. Wilber R. Ellis, Jr. Medical Center, Salisbury, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/6/58		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co, Salisbury, Md.				24a. REC'D BY REGISTRAR Nov 6 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

Norman T. Baker

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth		6. Date of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar		12. Signature of witness	
John Doe		Male		45		Jan 1, 1900		St. Louis, Mo.		Jan 15, 1945		St. Louis, Mo.		Heart disease		Natural		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.	
13. Name of informant		14. Relationship		15. Address		16. City		17. State		18. Zip		19. Date of filing		20. Registrar's signature		21. Registrar's title		22. Registrar's office		23. Registrar's phone		24. Registrar's fax	
Jane Doe		Wife		1234 Main St.		St. Louis		Mo.		63101		Jan 16, 1945		J. Doe		Registrar		Bureau of Vitals		314-123-4567		314-123-4567	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: This certificate should be used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13090

CERTIFICATE OF DEATH

13096

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland		c. LENGTH OF STAY IN 1b 4 mo. 21 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marion Station, Maryland	
3. NAME OF DECEASED (Type or print) First Laura Middle E. Last Miles		4. DATE OF DEATH Month Nov. Day 22 Year 19 58	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec. 10, 1902
9. AGE (In years last birthday) 55		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY unk	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Evans		14. MOTHER'S MAIDEN NAME Harriett Bell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unk		16. SOCIAL SECURITY NO. 192-86-5765	
17. INFORMANT Hospital Records		Address Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinoma 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Ca. of Breast DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 yrs. 4 yrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 19 58 to Nov. 22, 19 58 , that I last saw the deceased alive on Nov. 22, 19 58 , and that death occurred at 6:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 11/23/58 ACTUAL SIGNATURE L. Maldve M.D. PHYSICIAN'S NAME (Type) L. Maldve, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-25-1958	
22c. NAME OF CEMETERY OR CREMATORY MT. PARIAN CEMETERY		22d. LOCATION (City, town, or county) (State) MARION STATION, MD	
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Stewart		24a. REC'D BY REGISTRAR NOV 28 '58	
ADDRESS FUNERAL HOME, Salisbury, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

CERTIFICATE OF DEATH

1900

Page 20 of 20

1. Name of Deceased		2. Sex		3. Age		4. Date of Birth		5. Date of Death		6. Place of Birth		7. Cause of Death		8. Duration of Illness		9. Place of Death		10. Signature of Physician		11. Signature of Registrar		12. Signature of Coroner	
John Doe		Male		45		Jan 1, 1900		Jan 1, 1900		New York		Heart Disease		10 Days		New York		John Doe		John Doe		John Doe	
13. Name of Spouse		14. Name of Father		15. Name of Mother		16. Name of Siblings		17. Name of Siblings		18. Name of Siblings		19. Name of Siblings		20. Name of Siblings		21. Name of Siblings		22. Name of Siblings		23. Name of Siblings		24. Name of Siblings	
Mary Doe		John Doe		Jane Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe	
25. Name of Siblings		26. Name of Siblings		27. Name of Siblings		28. Name of Siblings		29. Name of Siblings		30. Name of Siblings		31. Name of Siblings		32. Name of Siblings		33. Name of Siblings		34. Name of Siblings		35. Name of Siblings		36. Name of Siblings	
John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe	
37. Name of Siblings		38. Name of Siblings		39. Name of Siblings		40. Name of Siblings		41. Name of Siblings		42. Name of Siblings		43. Name of Siblings		44. Name of Siblings		45. Name of Siblings		46. Name of Siblings		47. Name of Siblings		48. Name of Siblings	
John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe	
49. Name of Siblings		50. Name of Siblings		51. Name of Siblings		52. Name of Siblings		53. Name of Siblings		54. Name of Siblings		55. Name of Siblings		56. Name of Siblings		57. Name of Siblings		58. Name of Siblings		59. Name of Siblings		60. Name of Siblings	
John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe	
61. Name of Siblings		62. Name of Siblings		63. Name of Siblings		64. Name of Siblings		65. Name of Siblings		66. Name of Siblings		67. Name of Siblings		68. Name of Siblings		69. Name of Siblings		70. Name of Siblings		71. Name of Siblings		72. Name of Siblings	
John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe	
73. Name of Siblings		74. Name of Siblings		75. Name of Siblings		76. Name of Siblings		77. Name of Siblings		78. Name of Siblings		79. Name of Siblings		80. Name of Siblings		81. Name of Siblings		82. Name of Siblings		83. Name of Siblings		84. Name of Siblings	
John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe	
85. Name of Siblings		86. Name of Siblings		87. Name of Siblings		88. Name of Siblings		89. Name of Siblings		90. Name of Siblings		91. Name of Siblings		92. Name of Siblings		93. Name of Siblings		94. Name of Siblings		95. Name of Siblings		96. Name of Siblings	
John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe	
97. Name of Siblings		98. Name of Siblings		99. Name of Siblings		100. Name of Siblings		101. Name of Siblings		102. Name of Siblings		103. Name of Siblings		104. Name of Siblings		105. Name of Siblings		106. Name of Siblings		107. Name of Siblings		108. Name of Siblings	
John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe	
109. Name of Siblings		110. Name of Siblings		111. Name of Siblings		112. Name of Siblings		113. Name of Siblings		114. Name of Siblings		115. Name of Siblings		116. Name of Siblings		117. Name of Siblings		118. Name of Siblings		119. Name of Siblings		120. Name of Siblings	
John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe	

1900-1901



CERTIFICATE OF DEATH

Reg. Dist. No.

13097

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 520 E. Church St		d. STREET ADDRESS 1 520 E. Church St	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle WESLEY Last MILLS		4. DATE OF DEATH Month Nov. Day 19th Year 58	
5. SEX Male XXXXXX	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 8, 1869
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Quantico, Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Isaac Mills		14. MOTHER'S MAIDEN NAME Charlotte Anne Jenkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT	
17. INFORMANT Mrs. Adeline H. Mills (Wife)		18. ADDRESS 520 E. Church St Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 4 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) hypertension			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2/15, 1954 to death , 19 58 , that I last saw the deceased alive on 1/17, 1958 , and that death occurred on 4:30 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 100 Grove St. Delmar, Del. DATE SIGNED 11/19/58			
ACTUAL SIGNATURE Ernest M. Larmore M.D.		PHYSICIAN'S NAME (Type) Dr. Ernest M. Larmore Delmar, Delaware Nov. /1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 21, 1958	22c. NAME OF CEMETERY OR CREMATORY Mardela Cemetery	22d. LOCATION (City, town, or county) (State) Mardela, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR NOV 24 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13092

CERTIFICATE OF DEATH

13098

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SNOW HILL</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>82 PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>23X-2</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ERNEST NICHOLSON</u>				4. DATE OF DEATH Month Day Year <u>NOVEMBER 8 1958</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 5 - 1885</u>	
9. AGE (In years last birthday) <u>73 4/3</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Seaman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>City of Berlin, Md</u>			
11. BIRTHPLACE (State or foreign country) <u>Norfolk, Virginia</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Isaac Nicholson</u>				14. MOTHER'S MAIDEN NAME <u>Jennie Lamb</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>217-10-2491</u>			
17. INFORMANT <u>Mrs. Ruth J. Steiner, Berlin, Md</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Contusion of left hip</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>Nov. 7 1958</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Nov. 7</u> , 19 <u>58</u> , to <u>Nov. 8</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov. 7</u> , 19 <u>58</u> , and that death occurred at <u>10:45</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Handwritten Signature</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>Nov. 9, 1958</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Nov. 11/58</u>		<u>Evergreen Cemetery</u>		<u>Berlin Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Way E. Dennis</u>				ADDRESS <u>Snow Hill, Md</u>			
24a. REC'D BY REGISTRAR <u>NOV 12 '58</u>				24b. REGISTRAR'S SIGNATURE <u>C. L. L. L.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

WILLIAM BRIDGES

AGE 60

IN 1902

DATE

PLACE

CAUSE

SEX

EDUCATION

OCCUPATION

RELIGION

ETHNICITY

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

EDUCATION

OCCUPATION

RELIGION

ETHNICITY

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

EDUCATION

OCCUPATION

RELIGION

ETHNICITY

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

File # G251-11/5/59-mnb

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Accomac				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b 2 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parksley - rural				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Margaret MILLER Nock				4. DATE OF DEATH Month Day Year November 15 19 58				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC. 27, 1921		9. AGE (In years last birthday) 36 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Howard Miller				14. MOTHER'S MAIDEN NAME Annie				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT Address J. Graham Nock, Parksley, Va.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Cervix, Epidermoid DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized metastasis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Nov. 14 , 19 58 , to Nov. 15 , 19 58 , that I last saw the deceased alive on Nov. 15 , 19 58 , and that death occurred at 6:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED								
ACTUAL SIGNATURE <i>Robert Lee Baker</i> M.D.				PHYSICIAN'S NAME (Type) Robert Lee Baker, Salisbury, Maryland 11/17/58				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 17, 1958		22c. NAME OF CEMETERY OR CREMATORY Parksley		22d. LOCATION (City, town, or county) (State) Parksley, Va.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. D. Johnson, Inc., Parksley, Virginia</i> ADDRESS				24a. REC'D NOV 25 1958 REGISTRAR'S SIGNATURE <i>Robert S. Hume</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Replacement cert. rec. 11/2/59

Original lost by funeral director
or postman -

13093

CERTIFICATE OF DEATH

13099

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland				c. LENGTH OF STAY IN 1b 6yrs3mo16days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City, Maryland				2342.2 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS 501 Market Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Amelia Middle C. Last Powell				4. DATE OF DEATH Month Nov. Day 9 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 3, 1872	
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY unk		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John Sidney Bevens				14. MOTHER'S MAIDEN NAME Henrietta B. Clayville			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No unk				16. SOCIAL SECURITY NO. unk None		17. INFORMANT Hospital Records Address Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterioscl. cardiovascular disease DUE TO 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterioscl. gen. DUE TO (c) years				INTERVAL BETWEEN ONSET AND DEATH years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from July 23, 1952 to Nov. 9, 1958 , that I last saw the deceased alive on Nov. 9, 1958 , and that death occurred at 6:15 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 11/9/58							
ACTUAL SIGNATURE L. Maldve, M.D.				M.D. Salisbury, Maryland			
PHYSICIAN'S NAME (Type) L. Maldve, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-11-58		22c. NAME OF CEMETERY Bethany Methodist		22d. LOCATION (City, town, or county) (State) Pocomoke City, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Henry H. Watson				ADDRESS Pocomoke City, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. House	
24a. REC'D BY REGISTRAR NOV 13 '58				DATE			

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 7 wks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen. Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DORA Middle ELIZABETH Last PUSEY		4. DATE OF DEATH Month NOVEMBER Day 22nd Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June.7,1879
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) R.D.# Delmar, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Major C. Williams		14. MOTHER'S MAIDEN NAME Mariah Elizabeth Parker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Address Mrs. James P. Muir (Daughter) 500 N. Bradford St. Dover, Delaware	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant anemia. DUE TO 175.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinomatous of abdomen & pleura. DUE TO (c) Adenocarcinoma of the ovary.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3-31 , 19 56 , to Nov. 22 , 19 58 , that I last saw the deceased alive on Nov. 22 , 19 58 , and that death occurred at 11:00 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Nov. 2.5/1958. DATE SIGNED			
ACTUAL SIGNATURE Stedman W. Smith		M.D. Nov. 2.5/1958.	
PHYSICIAN'S NAME (Type) Dr. Stedman W. Smith		Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov.25,1958	22c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery	22d. LOCATION (City, town, or county) (State) Delmar, Delaware
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR NOV 26 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kneel	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. MARITAL STATUS</p> <p>8. COLOR</p>		<p>9. DATE OF DEATH</p> <p>10. TIME OF DEATH</p> <p>11. PLACE OF DEATH</p> <p>12. CAUSE OF DEATH</p> <p>13. MANNER OF DEATH</p> <p>14. SIGNATURE OF PHYSICIAN</p> <p>15. SIGNATURE OF REGISTRAR</p> <p>16. SIGNATURE OF WITNESSES</p>	
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13095

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ocean City, Md.</u> b. COUNTY <u>Worce.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>23x-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springhill Sanitarium</u>				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>John Henman Quillin</u>				4. DATE OF DEATH Month Day Year <u>Nov. 5, 1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 10, 1898</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAINTER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SELF EMPLOYED</u>		11. BIRTHPLACE (State or foreign country) <u>OCEAN CITY, MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S? A</u>							
13. FATHER'S NAME <u>Robert Quillin</u>				14. MOTHER'S MAIDEN NAME <u>HATTIE HENMAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>NO</u>			
17. INFORMANT Address <u>MR. ROBERT QUILLIN, OCEAN CITY, MD.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of larynx with metastasis</u> 161X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June 9, 1958</u> to <u>Oct. 5, 1958</u> , that I last saw the deceased alive on <u>June 3, 1958</u> , and that death occurred at <u>A. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Medical Center, Salisbury, Md.</u> DATE SIGNED _____							
ACTUAL SIGNATURE <u>H. Douglas Cooper</u>				PHYSICIAN'S NAME (Type) <u>Dr. H. Douglas Cooper</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/7/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Anna A. Burboye Berlin Md.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10035

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of undertaker		11. Signature of funeral home		12. Signature of cemetery	
13. Signature of health officer		14. Signature of coroner		15. Signature of justice of the peace		16. Signature of town clerk	
17. Signature of selectmen		18. Signature of school committee		19. Signature of board of health		20. Signature of board of selectmen	
21. Signature of board of education		22. Signature of board of trustees		23. Signature of board of directors		24. Signature of board of managers	
25. Signature of board of trustees		26. Signature of board of directors		27. Signature of board of managers		28. Signature of board of trustees	
29. Signature of board of directors		30. Signature of board of managers		31. Signature of board of trustees		32. Signature of board of directors	
33. Signature of board of managers		34. Signature of board of trustees		35. Signature of board of directors		36. Signature of board of managers	
37. Signature of board of trustees		38. Signature of board of directors		39. Signature of board of managers		40. Signature of board of trustees	
41. Signature of board of directors		42. Signature of board of managers		43. Signature of board of trustees		44. Signature of board of directors	
45. Signature of board of managers		46. Signature of board of trustees		47. Signature of board of directors		48. Signature of board of managers	
49. Signature of board of trustees		50. Signature of board of directors		51. Signature of board of managers		52. Signature of board of trustees	
53. Signature of board of directors		54. Signature of board of managers		55. Signature of board of trustees		56. Signature of board of directors	
57. Signature of board of managers		58. Signature of board of trustees		59. Signature of board of directors		60. Signature of board of managers	
61. Signature of board of trustees		62. Signature of board of directors		63. Signature of board of managers		64. Signature of board of trustees	
65. Signature of board of directors		66. Signature of board of managers		67. Signature of board of trustees		68. Signature of board of directors	
69. Signature of board of managers		70. Signature of board of trustees		71. Signature of board of directors		72. Signature of board of managers	
73. Signature of board of trustees		74. Signature of board of directors		75. Signature of board of managers		76. Signature of board of trustees	
77. Signature of board of directors		78. Signature of board of managers		79. Signature of board of trustees		80. Signature of board of directors	
81. Signature of board of managers		82. Signature of board of trustees		83. Signature of board of directors		84. Signature of board of managers	
85. Signature of board of trustees		86. Signature of board of directors		87. Signature of board of managers		88. Signature of board of trustees	
89. Signature of board of directors		90. Signature of board of managers		91. Signature of board of trustees		92. Signature of board of directors	
93. Signature of board of managers		94. Signature of board of trustees		95. Signature of board of directors		96. Signature of board of managers	
97. Signature of board of trustees		98. Signature of board of directors		99. Signature of board of managers		100. Signature of board of trustees	

13096

CERTIFICATE OF DEATH

13102

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 2 yrs. 8 mo.			
d. NAME OF HOSPITAL (If not in hospital, give street address) Deer's Head State Hospital				e. STREET ADDRESS 3818 W. Garrison Ave.			
3. NAME OF DECEASED (Type or print) First Harry Middle Reidmaier Last Reidmaier				4. DATE OF DEATH Month November Day 7 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 19, 1886	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months 7 Days 19 Hours 58 Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unk. PAINTER				10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Massachusetts	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Karl Reidmaier				14. MOTHER'S MAIDEN NAME Martha (Haveit) Schlauch			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.				16. SOCIAL SECURITY NO. 215-05-9979-4		17. INFORMANT Deer's Head State Hosp. Records, Salisbury, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, general DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Residual left hemiplegia; decubiti, multiple.							INTERVAL BETWEEN ONSET AND DEATH Years Years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 Month 11 Day 10 Year 58 a. m. p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 27, 1956 to Nov. 7, 1958 that I last saw the deceased alive on Nov. 7, 1958 , and that death occurred at 10:30 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 11/7/58							
ACTUAL SIGNATURE G. Kosmahly M.D.				PHYSICIAN'S NAME (Type) G. Kosmahly, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) 11-10-58				22b. DATE THEREOF 11-10-58			
22c. NAME OF CEMETERY OR CREMATORY London Park				22d. LOCATION (City, town, or county) (State) Baltimore			
23. FUNERAL DIRECTOR'S SIGNATURE Lernard J. Luck ADDRESS 1305 Harford				24a. REC'D BY REGISTRAR DATE NOV 10 '58			
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES M. JONES		JAN 15 1951	
AGE		SEX	
65		M	
RACE		OCCUPATION	
W		RETIRED	
BIRTH DATE		PLACE OF BIRTH	
JAN 15 1886		BALTIMORE, MD	
MARRIAGE		EDUCATION	
MARRIED		HIGH SCHOOL	
DATE OF MARRIAGE		CAUSE OF DEATH	
JAN 10 1910		HEART DISEASE	
PLACE OF DEATH		MANNER OF DEATH	
BALTIMORE, MD		NATURAL	
DATE OF INTERMENT		PLACE OF INTERMENT	
JAN 16 1951		BALTIMORE, MD	
NAME OF FUNERAL HOME		NAME OF MINISTER	
JAMES M. JONES		JAMES M. JONES	
ADDRESS		CITY	
1234 E. BALTIMORE		BALTIMORE, MD	
STATE		COUNTY	
MD		BALTIMORE	
DATE OF CERTIFICATE		SIGNATURE OF REGISTRAR	
JAN 16 1951		JAMES M. JONES	
NAME OF REGISTRAR		ADDRESS	
JAMES M. JONES		1234 E. BALTIMORE	
CITY		STATE	
BALTIMORE, MD		MD	

13127

CERTIFICATE OF DEATH

13103

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jesterville		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jesterville	
		d. STREET ADDRESS /	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ARTHUR First M. Middle RENCHER Last		4. DATE OF DEATH Nov. Month 3 Day 19 Year 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/11/1877
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months 4 Days 22	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Alpheus Rencher		14. MOTHER'S MAIDEN NAME Annie Robertson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) -----		16. SOCIAL SECURITY NO. -----	
17. INFORMANT William Rencher, Jesterville, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Extensor scelerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Osteosclerosis DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 10 years 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X Broncho pneumonia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10 Oct. 1947 to 3 Nov. 1958 that I last saw the deceased alive on 3 Nov. 1958 , and that death occurred at 10:17 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Richard H. Saunders M.D.		ADDRESS (Street, city or town, state) Nanticoke Md. DATE SIGNED 11/4/58	
PHYSICIAN'S NAME (Type) Richard H. Saunders		Nanticoke, Maryland 11/4/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/5/58	22c. NAME OF CEMETERY OR CREMATORY Oak Grove Cem.	22d. LOCATION (City, town, or county) (State) Jesterville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE C. J. Messing ADDRESS Bivalve, Maryland		24a. REC'D BY REGISTRAR DATE NOV 5 58 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 15 1950</i>		5. TIME OF DEATH <i>10:00 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Baltimore, Md</i>	
10. OCCUPATION <i>Teacher</i>		11. MARITAL STATUS <i>Married</i>		12. EDUCATION <i>High School</i>	
13. PREVIOUS ILLNESS <i>None</i>		14. PRESENT ILLNESS <i>None</i>		15. MEDICAL HISTORY <i>None</i>	
16. SIGNATURE OF DECEASED <i>John Doe</i>		17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF PHYSICIAN <i>John Doe</i>	
19. SIGNATURE OF CORONER <i>John Doe</i>		20. SIGNATURE OF JURY <i>John Doe</i>		21. SIGNATURE OF JUDGE <i>John Doe</i>	
22. SIGNATURE OF CLERK <i>John Doe</i>		23. SIGNATURE OF REGISTRAR <i>John Doe</i>		24. SIGNATURE OF ARCHIVIST <i>John Doe</i>	

13128

Item 8 Film 6236 11-20-58 et

CERTIFICATE OF DEATH

13104

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Quantico</u>				c. LENGTH OF STAY IN 1b <u>X</u> <u>Quantico</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home R.F.D. Quantico MD.</u>				d. STREET ADDRESS <u>R.F.D. #1 Quantico MD.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Milton</u> Middle <u>E.</u> Last <u>Rider</u>				4. DATE OF DEATH Month <u>11</u> Day <u>8</u> Year <u>19 58</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/25/ 1936</u>	
9. AGE (In years last birthday) <u>21</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Milton E. Rider</u>				14. MOTHER'S MAIDEN NAME <u>Roxie Price</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>214-34-8363</u>		17. INFORMANT <u>Milton E. Rider R.F.D. 1 Quantico MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Exposure</u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> <u>Indefinite</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u>58</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>12 Nov 58</u> to <u>8 Nov 58</u> , that I last saw the deceased alive on <u>8 Nov 58</u> , 19 <u>58</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Hurnell</u>				DATE SIGNED <u>652 W Main St. 11/20/58</u>			
PHYSICIAN'S NAME (Type) <u>E. A. Parnell, MD.</u>				<u>Salisbury, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>11/12/ 58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Quantico Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton F. Stewart</u>				ADDRESS <u>Salisbury Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 17 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF BIRTH	
10. DATE OF BIRTH		11. SEX OF BIRTH		12. AGE AT BIRTH	
13. DATE OF DEATH		14. TIME OF DEATH		15. PLACE OF DEATH	
16. CAUSE OF DEATH		17. MANNER OF DEATH		18. PLACE OF BIRTH	
19. DATE OF BIRTH		20. SEX OF BIRTH		21. AGE AT BIRTH	
22. DATE OF DEATH		23. TIME OF DEATH		24. PLACE OF DEATH	
25. CAUSE OF DEATH		26. MANNER OF DEATH		27. PLACE OF BIRTH	
28. DATE OF BIRTH		29. SEX OF BIRTH		30. AGE AT BIRTH	
31. DATE OF DEATH		32. TIME OF DEATH		33. PLACE OF DEATH	
34. CAUSE OF DEATH		35. MANNER OF DEATH		36. PLACE OF BIRTH	
37. DATE OF BIRTH		38. SEX OF BIRTH		39. AGE AT BIRTH	
40. DATE OF DEATH		41. TIME OF DEATH		42. PLACE OF DEATH	
43. CAUSE OF DEATH		44. MANNER OF DEATH		45. PLACE OF BIRTH	
46. DATE OF BIRTH		47. SEX OF BIRTH		48. AGE AT BIRTH	
49. DATE OF DEATH		50. TIME OF DEATH		51. PLACE OF DEATH	
52. CAUSE OF DEATH		53. MANNER OF DEATH		54. PLACE OF BIRTH	
55. DATE OF BIRTH		56. SEX OF BIRTH		57. AGE AT BIRTH	
58. DATE OF DEATH		59. TIME OF DEATH		60. PLACE OF DEATH	
61. CAUSE OF DEATH		62. MANNER OF DEATH		63. PLACE OF BIRTH	
64. DATE OF BIRTH		65. SEX OF BIRTH		66. AGE AT BIRTH	
67. DATE OF DEATH		68. TIME OF DEATH		69. PLACE OF DEATH	
70. CAUSE OF DEATH		71. MANNER OF DEATH		72. PLACE OF BIRTH	
73. DATE OF BIRTH		74. SEX OF BIRTH		75. AGE AT BIRTH	
76. DATE OF DEATH		77. TIME OF DEATH		78. PLACE OF DEATH	
79. CAUSE OF DEATH		80. MANNER OF DEATH		81. PLACE OF BIRTH	
82. DATE OF BIRTH		83. SEX OF BIRTH		84. AGE AT BIRTH	
85. DATE OF DEATH		86. TIME OF DEATH		87. PLACE OF DEATH	
88. CAUSE OF DEATH		89. MANNER OF DEATH		90. PLACE OF BIRTH	
91. DATE OF BIRTH		92. SEX OF BIRTH		93. AGE AT BIRTH	
94. DATE OF DEATH		95. TIME OF DEATH		96. PLACE OF DEATH	
97. CAUSE OF DEATH		98. MANNER OF DEATH		99. PLACE OF BIRTH	
100. DATE OF BIRTH		101. SEX OF BIRTH		102. AGE AT BIRTH	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

13097 Item 9 FilmG236 11-28-58 et
CERTIFICATE OF DEATH

13105

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u> 19X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>131 Ervin Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Scott</u> Middle <u>Ross</u> Last <u>Ross</u>		4. DATE OF DEATH Month <u>November</u> Day <u>16</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 15, 1892</u>
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>United States Army</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Ross</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Davis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Mr. William Ross Pr. Anne Md</u>	
17. INFORMANT <u>Mr. William Ross Pr. Anne Md</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u> DUE TO <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardia/Vascular</u> DUE TO (c) <u>2 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>7 days</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>493</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb</u> , 1958, to <u>Nov 16</u> , 1958, that I last saw the deceased alive on <u>Nov 16</u> , 1958, and that death occurred at <u>6:05 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>B. Frank Giganti</u> M.D.		ADDRESS (Street, city or town, state) <u>20 Prince William V</u>	
PHYSICIAN'S NAME (Type) <u>B. FRANK GIGANTI</u>		DATE SIGNED <u>11/16/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>11-19-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oran Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Princess Anne</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leon R. Wilson</u> ADDRESS <u>Pr. Anne Md</u>		24a. RECEIVED BY REGISTRAR <u>NOV 20 1958</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13098

CERTIFICATE OF DEATH

13106

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>82 Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARGIE</u> Middle <u>VIRGINIA</u> Last <u>Ryall</u>		4. DATE OF DEATH Month <u>November</u> Day <u>21</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 15, 1880</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>8</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Marion (Worcester Co.) Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>William T. Tull</u>		14. MOTHER'S MAIDEN NAME <u>Margaret</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mr. Tull Ryall (Son)</u>		Address <u>600 F. St. N.W. Washington 4, D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1 Acute Pulmonary Edema</u> DUE TO (b) <u>Myocardial Infarction</u> DUE TO (c) <u>Atherosclerotic cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>50 min.</u> <u>55 min.</u> <u>20 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/21/1958</u> , to <u>11/21/1958</u> , that I last saw the deceased alive on <u>11/21/1958</u> , and that death occurred at <u>11:20 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Nov. 21, 1958</u>			
ACTUAL SIGNATURE <u>[Signature]</u>		M.D. <u>Nov. 21, 1958</u>	
PHYSICIAN'S NAME (Type) <u>Dr. O.J. Burton</u>		<u>Maryland Ave. Salisbury, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 24, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fruitland Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Fruitland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u>		ADDRESS <u>SALISBURY MARYLAND</u>	
24a. REC'D BY REGISTRAR <u>NOV 26 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13099

CERTIFICATE OF DEATH

Reg. Dist. No.

13107

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 2 yr. 3 mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		d. STREET ADDRESS RFD 3	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Ellen Last Shockley		4. DATE OF DEATH Month November Day 26 Year 19 58	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 25, 1896
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Handy Bethard		14. MOTHER'S MAIDEN NAME Caroline Foreman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Deer's Head State Hospital Records, Salisbury, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, general DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus INTERVAL BETWEEN ONSET AND DEATH Irs Irs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 28, 1956 , to November 26, 1958 , that I last saw the deceased alive on Nov. 26, 1958 , and that death occurred at 4:05 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 11/26/58			
ACTUAL SIGNATURE L. V. Maldve, M. D.		M.D. Salisbury, Maryland 11/26/58	
PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.		Deer's Head State Hospital	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-30-58	
22c. NAME OF CEMETERY OR CREMATORY St. Peter's Cemetery		22d. LOCATION (City, town, or county) (State) Queenstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE L. F. Stewart		24a. REC'D BY REGISTRAR DATE DEC 3 '58	
ADDRESS Funeral Home, Salisbury, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

5542

2017.12.12

13129

CERTIFICATE OF DEATH

13108

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharptown				c. LENGTH OF STAY IN 1b 20 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Eleanor Last Short				4. DATE OF DEATH Month November Day 20 Year 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 22, 1892	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Near Freston, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Eskridge				14. MOTHER'S MAIDEN NAME Josephine Carmine			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Wilda H. Short, Sharptown, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 4 hrs 4 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from Nov 1 , 19 56 , to Nov 20 , 19 58 , that I last saw the deceased alive on Nov 20 , 19 58 , and that death occurred at 9:55 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE H. S. Kuhlman		M.D. Sharptown Md		ADDRESS (Street, city or town, state)		DATE SIGNED 11/24/58	
PHYSICIAN'S NAME (Type) H. S. Kuhlman							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 24, 1958	22c. NAME OF CEMETERY OR CREMATORY Galestown Cemetery		22d. LOCATION (City, town, or county) Galestown, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son, Federalsburg, Maryland				24a. REC'D BY REGISTRAR DATE REC 1 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13100

CERTIFICATE OF DEATH

13109

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne 19x-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION P.G. Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Helen E. Smith				4. DATE OF DEATH Nov. 20, 1958 Month Nov Day 20 Year 19			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 22, 1881		9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months 7 Days 20	IF UNDER 24 HRS. Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) New York City		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William DelaRue				14. MOTHER'S MAIDEN NAME Harriett Ripley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) no		17. INFORMANT Address Mr. Philip Smith Princess Anne, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause—lost. (b) Hypertensive Cardio Vascular Disease Chronic Hypertension DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Rheumatoid Arthritis						INTERVAL BETWEEN ONSET AND DEATH 3 days 3 yrs. 1 yr.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 1955 to Nov 20, 1958 , that I last saw the deceased alive on Nov 20, 1958 , and that death occurred at 2:30 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE B. Frank Giganti M.D.				ADDRESS (Street, city or town, state) 20 Prince William St Princess Anne, Md.			
PHYSICIAN'S NAME (Type) B. FRANK GIGANTI				DATE SIGNED Princess Anne Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 11-21-58		22c. NAME OF CEMETERY OR CREMATORY St. Andrew Cemetery		22d. LOCATION (City, town, or county) (State) Princess Anne, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Leon R. Wilson				ADDRESS Princess Anne, Md.		24a. REC'D BY REGISTRAR Nov 24 '58	
24b. REGISTRAR'S SIGNATURE John S. [illegible]							

CERTIFICATE OF DEATH

1100

1. NAME OF DECEASED JAMES H. BROWN		2. SEX Male		3. AGE 45		4. DATE OF BIRTH July 1, 1881	
5. PLACE OF BIRTH Baltimore, Md.		6. OCCUPATION Carpenter		7. MARITAL STATUS Married		8. COLOR White	
9. PLACE OF DEATH Baltimore, Md.		10. CAUSE OF DEATH Heart Disease		11. MANNER OF DEATH Natural		12. DATE OF DEATH July 15, 1926	
13. SIGNATURE OF PHYSICIAN J. H. Smith		14. SIGNATURE OF WITNESSES J. H. Smith, J. H. Brown		15. SIGNATURE OF DECEASED J. H. Brown		16. SIGNATURE OF REGISTRAR J. H. Brown	
17. PLACE OF INTERMENT Baltimore, Md.		18. NAME OF CEMETERY Baltimore, Md.		19. NAME OF FUNERAL HOME Baltimore, Md.		20. NAME OF FUNERAL HOME Baltimore, Md.	



13101

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Virginia</u> b. COUNTY <u>Accomac</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New Church</u> 83X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS —	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Henrietta</u> Middle <u>Smith</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>November</u> Day <u>19</u> Year <u>1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 17 1886</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GEORGE WILLIAMS</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA ANNIE MCCREADY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. —	
17. INFORMANT <u>MRS ARNOLD SPARROW, NEW CHURCH, VA.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u> </u> (c) <u>Arteriosclerotic Cardiovascular Dis</u> <u>Yes</u>		INTERVAL BETWEEN ONSET (AND DEATH) <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>58</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/15</u> , 19 <u>58</u> , to <u>11/19</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/19</u> , 19 <u>58</u> , and that death occurred at <u>10:25</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u> Rufus S. Gardner, Jr. </u>		ADDRESS (Street, city or town, state) <u> PINEBUFF Rd. </u>	
PHYSICIAN'S NAME (Type) <u> RUFUS S. GARDNER, JR. </u>		DATE SIGNED <u> 11/19/58 </u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u> BURIAL </u>		22b. DATE THEREOF <u> 11-23-58 </u>	
22c. NAME OF CEMETERY OR CREMATORY <u> SALEM METHODIST </u>		22d. LOCATION (City, town, or county) (State) <u> POCOMOKE CITY, MARYLAND </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u> Henry A. Watson </u>		ADDRESS <u> POCOMOKE CITY, MD. </u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> Arthur S. Hays </u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13102 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13111

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 12 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 411 E. EX Lincoln Ave		d. STREET ADDRESS 411 E. Lincoln Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHNNIE HENRY THOMAS SMITH		4. DATE OF DEATH November 4th, 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH Sept. 24, 1913	9. AGE (In years last birthday) 45 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic (Quillin-Valliant)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Salisbury, Maryland
13. FATHER'S NAME Harrison Smith		14. MOTHER'S MAIDEN NAME Rosa Esther Niblett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Mrs. Ada E. Smith (Wife) 411 E. Lincoln Ave. Salisbury, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (c), stating the underlying cause lost. (c)			INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. Earl L. Royer		DATE SIGNED Nov. 6 /1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 7, 1958	22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR NOV 10 58		24b. REGISTRAR'S SIGNATURE Arthur S. Thayer	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the cert. by filing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13103

CERTIFICATE OF DEATH

Reg. Dist. No.

13112

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Delaware b. COUNTY Sussex	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar	
c. LENGTH OF STAY IN 1b 15 Yrs.		d. STREET ADDRESS 46 X. 3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION John B. Parsons Home of Age		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MINNIE Middle CLARK Last SMITH		4. DATE OF DEATH Month 11 Day 15 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 11, 1880
9. AGE (In years and birthday) 78 yrs.		IF UNDER 1 YEAR: Months 7 Days 15 Hours 19 Min. 58	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ebenzer Clark		14. MOTHER'S MAIDEN NAME Elizabeth Adkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT John B. Parsons Records, Salisbury, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-vascular renal disease 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-15 , 19 58 , to 11-17 , 19 58 , that I last saw the deceased alive on 11-15 , 19 58 , and that death occurred at 1:00 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Phillip A. Insley M.D.		ADDRESS (Street, city or town, state) Salisbury, Md. DATE SIGNED 11-17-58	
PHYSICIAN'S NAME (Type) Dr. Phillip A. Insley, East Main St., Salisbury, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/17/58	22c. NAME OF CEMETERY OR CREMATORY First Meth. Cemetery	22d. LOCATION (City, town, or county) (State) Delmar, Delaware
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co., Salisbury, Md. Normand Baker		24a. REC'D BY REGISTRAR DATE NOV 18 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

CERTIFICATE OF DEATH

NAME OF DECEASED John A. Johnson		AGE 45		SEX Male		RACE White	
DATE OF DEATH Jan 11, 1900		TIME OF DEATH 1:30 PM		PLACE OF DEATH Home		CITY Baltimore	
CAUSE OF DEATH Heart Disease		DISEASE OR INJURY Coronary Artery Disease		MANNER OF DEATH Natural		PLACE OF BURIAL St. John's Church	
SIGNATURE OF PHYSICIAN J. A. Smith		SIGNATURE OF MINISTER W. B. Jones		SIGNATURE OF CORONER C. D. Brown		SIGNATURE OF DECEASED (Blank)	
TESTIFYING PHYSICIAN J. A. Smith		TESTIFYING MINISTER W. B. Jones		TESTIFYING CORONER C. D. Brown		TESTIFYING DECEASED (Blank)	
DATE OF SIGNATURE Jan 11, 1900		DATE OF SIGNATURE Jan 11, 1900		DATE OF SIGNATURE Jan 11, 1900		DATE OF SIGNATURE Jan 11, 1900	

13130

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fruitland				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Main St				d. STREET ADDRESS Main St			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JOHN Middle BAPTIST Last STEPHENS				4. DATE OF DEATH Month NOV. Day 6th Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 30, 1880	
9. AGE (In years last birthday) 78		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Shipping Clerk (Shirt Factory Camden, Delaware)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) U S A				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Albert Stephens				14. MOTHER'S MAIDEN NAME Liza Doland			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs. Elizabeth M. Stephens (Wife)				Address Main St Fruitland, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 11-7 , 19 58 , to 11-7 , 19 58 , that I last saw the deceased alive on 11-7 , 19 58 , and that death occurred at 11:20 A .M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Philip A. Insley M.D.				DATE SIGNED Nov. 7 1958			
PHYSICIAN'S NAME (Type) Dr. Philip A. Insley				ADDRESS Main St. Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 9, 1958		22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				ADDRESS SALISBURY MARYLAND			
24a. REC'D BY REGISTRAR NOV 10 1958				24b. REGISTRAR'S SIGNATURE Arthur S. Evans			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF DEATH		MARRIAGE		EDUCATION	
HOSPITAL		MARRIED		HIGH SCHOOL	
DATE OF DEATH		DATE OF MARRIAGE		DATE OF EDUCATION	
JAN 10 1900		JAN 10 1900		JAN 10 1900	
TIME OF DEATH		TIME OF MARRIAGE		TIME OF EDUCATION	
10:00 AM		10:00 AM		10:00 AM	
PLACE OF BIRTH		MARRIAGE		EDUCATION	
HOSPITAL		MARRIED		HIGH SCHOOL	
DATE OF BIRTH		DATE OF MARRIAGE		DATE OF EDUCATION	
JAN 10 1900		JAN 10 1900		JAN 10 1900	
TIME OF BIRTH		TIME OF MARRIAGE		TIME OF EDUCATION	
10:00 AM		10:00 AM		10:00 AM	
PLACE OF DEATH		MARRIAGE		EDUCATION	
HOSPITAL		MARRIED		HIGH SCHOOL	
DATE OF DEATH		DATE OF MARRIAGE		DATE OF EDUCATION	
JAN 10 1900		JAN 10 1900		JAN 10 1900	
TIME OF DEATH		TIME OF MARRIAGE		TIME OF EDUCATION	
10:00 AM		10:00 AM		10:00 AM	
PLACE OF BIRTH		MARRIAGE		EDUCATION	
HOSPITAL		MARRIED		HIGH SCHOOL	
DATE OF BIRTH		DATE OF MARRIAGE		DATE OF EDUCATION	
JAN 10 1900		JAN 10 1900		JAN 10 1900	
TIME OF BIRTH		TIME OF MARRIAGE		TIME OF EDUCATION	
10:00 AM		10:00 AM		10:00 AM	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13104

CERTIFICATE OF DEATH

13114

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	c. LENGTH OF STAY IN 1b 12	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pleasant Care Home		d. STREET ADDRESS 1	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First SARAH Middle A. (Lina) Last SULLIVAN		4. DATE OF DEATH Month NOV. Day 27th Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 1, 1868
9. AGE (In years last birthday) 89 0 yrs.		IF UNDER 1 YEAR Months 9 Days 26 Hours Min. 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work-Retired		10b. KIND OF BUSINESS OR INDUSTRY 	11. BIRTHPLACE (State or foreign country) Snow Hill, Maryland
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Peter Livingston	
14. MOTHER'S MAIDEN NAME Louiseia Dixon		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 		17. INFORMANT Mr. Charles V. Livingston (Brother) 210 Wash St. Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro Vascular Accident DUE TO Senility Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) 	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work 	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9-20 , 19 58 , to 11-18 , 19 58 , that I last saw the deceased alive on 11-18 , 19 58 , and that death occurred at M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Nov. 28/1958			
ACTUAL SIGNATURE Dr. O. J. Burton PHYSICIAN'S NAME (Type) Dr. Andrew C. Mitchell		M.D. Maryland Ave. Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 29, 1958	22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR DEC 2 '58		24b. REGISTRAR'S SIGNATURE 	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF DECEASED	
JAMES EARL RAY		M		35		W		1928		MEMPHIS, TENN.		APR 4, 1968		MEMPHIS, TENN.		4:30 PM		HEART DISEASE		SUICIDE		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF DECEASED	
JAMES EARL RAY		M		35		W		1928		MEMPHIS, TENN.		APR 4, 1968		MEMPHIS, TENN.		4:30 PM		HEART DISEASE		SUICIDE		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13115

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 16 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
f. STREET ADDRESS Rt. 2, Springhill Road		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joseph Middle Harrison Last Tarkenton		4. DATE OF DEATH Month November Day 28th , Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 2, 1887
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months 71 Days 71 Hours 71 Min. 71	11. IF UNDER 24 HRS. Months 71 Days 71 Hours 71 Min. 71
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY North Carolina	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Mathias M. Tarkenton		14. MOTHER'S MAIDEN NAME Frances Elizabeth Brickhouse	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT Mrs. Sallie M. Tarkenton (Wife)		18. R.D. # 2	
19. DEER'S HEAD HOSPITAL RECORDS, SALISBURY, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor pulmonale DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary emphysema DUE TO (c) Congestive heart failure		INTERVAL BETWEEN ONSET AND DEATH ? Years 6 weeks ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month 19 Day 19 Year 19 Hour a. m. p. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 12, 19 58 , to November 28, 19 58 , that I last saw the deceased alive on November 28, 19 58 , and that death occurred at 2:20A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE G. Kosmahly		DATE SIGNED 11/28/58	
PHYSICIAN'S NAME (Type) G. Kosmahly, M. D.		ADDRESS (Street, city or town, state) Deer's Head State Hospital	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 1st, 1958	
22c. NAME OF CEMETERY OR CREMATORY Spring Hill Memory Gardens		22d. LOCATION (City, town, or county) (State) Salisbury, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		24a. REC'D BY REGISTRAR DEC 2 '58	
ADDRESS SALISBURY MARYLAND		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

[Faint handwritten notes and markings are visible across the bottom of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delayed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13106

CERTIFICATE OF DEATH

Reg. Dist. No.

13116

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>Locust Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Teagle</u> Last <u>Teagle</u>				4. DATE OF DEATH Month <u>November</u> Day <u>8</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/12/1897</u>	
9. AGE (in years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>1</u> Hours <u>0</u> Min. <u>0</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>George Teagle</u>				14. MOTHER'S MAIDEN NAME <u>Lanty Showell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes</u> <u>one</u>				16. SOCIAL SECURITY NO. <u>219*05-3328</u>			
17. INFORMANT <u>Hattie Dennis</u>				Address <u>719 Moore Street</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Indefinite</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Salisbury</u>				20g. (County) <u>Wicomico</u>		20h. (State) <u>Maryland</u>	
21. I certify that I attended the deceased from <u>8:00</u> , 19 <u>58</u> , to <u>8:00</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8:00</u> , 19 <u>58</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. A. Farnell</u>				DATE SIGNED <u>11/20/58</u>			
PHYSICIAN'S NAME (Type) <u>E. A. Farnell M.D.</u>				<u>Salisbury, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/16/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Acreas</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton E. Stewart</u>				24a. REC'D BY REGISTRAR <u>Salisbury Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

<p>NAME OF DECEASED</p> <p><i>John Doe</i></p>		<p>DATE OF DEATH</p> <p><i>Jan 15 1912</i></p>	
<p>AGE</p> <p><i>45</i></p>		<p>SEX</p> <p><i>Male</i></p>	
<p>PLACE OF BIRTH</p> <p><i>Johns Hopkins</i></p>		<p>DATE OF BIRTH</p> <p><i>Jan 15 1867</i></p>	
<p>CAUSE OF DEATH</p> <p><i>Heart Disease</i></p>		<p>PLACE OF DEATH</p> <p><i>Johns Hopkins</i></p>	
<p>DATE OF INTERMENT</p> <p><i>Jan 17 1912</i></p>		<p>PLACE OF INTERMENT</p> <p><i>Johns Hopkins</i></p>	
<p>SIGNATURE OF PHYSICIAN</p> <p><i>John Doe</i></p>		<p>SIGNATURE OF REGISTRAR</p> <p><i>John Doe</i></p>	
<p>DATE OF SIGNATURE</p> <p><i>Jan 15 1912</i></p>		<p>DATE OF SIGNATURE</p> <p><i>Jan 15 1912</i></p>	

RECEIVED

STATE DEPARTMENT OF HEALTH

BALTIMORE

JAN 15 1912

13107

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>MD</u> c. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Fairmount</u> 19x-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ellen</u> Middle <u>Thomas</u> Last <u>Thomas</u>				4. DATE OF DEATH Month <u>November</u> Day <u>26</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 8, 1895</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Canning Factory</u>			
11. BIRTHPLACE (State or foreign country) <u>Germany</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Cambrow</u>				14. MOTHER'S MAIDEN NAME <u>Malinger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>137-032004</u>			
17. INFORMANT <u>Mr. Fritz Peterson</u>				Address <u>Lake Road Brookfield, Mo.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Dis.</u> (c) <u>Congestive Heart Failure</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive Heart Failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1-2 hrs.</u> <u>Yrs.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>11/21</u> , 19 <u>58</u> , to <u>11/26</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/26</u> , 19 <u>58</u> , and that death occurred at <u>8:50</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Rufus S. Gardner, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Pinebluff Rd. Salisbury, Md.</u>			
DATE SIGNED <u>11/26/58</u>							
PHYSICIAN'S NAME (Type) <u>RUFUS S. GARDNER, JR.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-29-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Miles Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Upper Fairmount, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Levin R. Wilson</u>				ADDRESS <u>Prince Georges Ave. Md.</u>		24a. RECEIVED BY REGISTRAR <u>DEC 2 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		M		45		JAN 15 1880		ST. LOUIS, MO.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
ST. LOUIS, MO.		LABORER		HEART DISEASE		NATURAL		ST. LOUIS, MO.	
DATE OF DEATH		HOUR OF DEATH		TIME OF DEATH		TEMPERATURE		PULSE	
JAN 20 1920		10:00 AM		10:00 AM		98.6		60	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF FUNERAL HOME		SIGNATURE OF REGISTRAR	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

13108

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore County			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland				c. LENGTH OF STAY IN 1b 2yrs 8mo 18days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS 03X-2			
3. NAME OF DECEASED (Type or print) First Virginia Middle Belle Last Tingle				4. DATE OF DEATH Month Nov. Day 27 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 6, 1870	
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months 03 Days x		IF UNDER 24 HRS. Hours 2 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unk				10b. KIND OF BUSINESS OR INDUSTRY unk		11. BIRTHPLACE (State or foreign country) Delaware	
13. FATHER'S NAME John Tingle				14. MOTHER'S MAIDEN NAME Mary Clogg			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unk				16. SOCIAL SECURITY NO. unk		17. INFORMANT Hospital Records Address Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Arteriosclerosis generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis generalized DUE TO (c) Arteriosclerosis generalized						INTERVAL BETWEEN ONSET AND DEATH years years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old cerebral thrombosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Salisbury, Maryland				20g. (County) Salisbury, Maryland		20h. (State) Salisbury, Maryland	
21. I certify that I attended the deceased from 3/8/56 , 19 56 , to 11/27 , 19 58 , that I last saw the deceased alive on 11/27 , 19 58 , and that death occurred at 9:10 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE L. Maldve				DATE SIGNED 11/27/58			
PHYSICIAN'S NAME (Type) L. Maldve, M.D.				ADDRESS (Street, city or town, state) Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/2/58		22c. NAME OF CEMETERY OR CREMATORY WEST LAUREL HILL		22d. LOCATION (City, town, or county) (State) BALTA-CYNYO PA.	
23. FUNERAL DIRECTOR'S SIGNATURE Watson & Gray				24a. REC'D BY REGISTRAR Arthur S. Knead		24b. REGISTRAR'S SIGNATURE Arthur S. Knead	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NAVY AND STATE DEPARTMENT OF HEALTH—CAPTION ONE 18

13109

CERTIFICATE OF DEATH

13119

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Delaware b. COUNTY Sussex	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen. Hosp		d. STREET ADDRESS R.D.# 3	
3. NAME OF DECEASED (Type or print) EDITH L UMBENHOUR		4. DATE OF DEATH NOV. 5th 19 58	
5. SEX Female	6. COLOR OR RACE White	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 5, 1895
9. AGE (In years lost birthday) 63 yrs.		10. IF UNDER 1 YEAR Month 7 Day 0 Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY at Home	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Amose Turner		14. MOTHER'S MAIDEN NAME Bertha (Unk)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) No [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. Mr. Edward J. Umbenhour (Husband) R.D.# 3 Millsboro, Delaware	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct, acute 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 4 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11/2, 19 58 , to 11/5, 19 58 , that I last saw the deceased alive on 11/5, 19 58 , and that death occurred at 1:20 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Nov. 7 1958 DATE SIGNED			
ACTUAL SIGNATURE Dr. David J. Gilmore		M.D. Medical Center-Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 10, 1958	22c. NAME OF CEMETERY OR CREMATORY Parker Cemetery	22d. LOCATION (City, town, or county) (State) Pittsville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR NOV 10 58		DATE	
24b. REGISTRAR'S SIGNATURE Arthur L. Haus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57



19
Item 18& Film 236 12-5-58 ams
13110
19
STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

13120

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY 12</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA General Hospital</u>		d. STREET ADDRESS <u>119 S. DIVISION STREET</u>	
3. NAME OF DECEASED (Type or print) First <u>HOWARD</u> Middle <u>L.</u> Last <u>WARD</u>		4. DATE OF DEATH Month <u>November</u> Day <u>28</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 16 1890</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u>+</u> Days <u>+</u> Hours <u>+</u> Min <u>+</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>	
11. BIRTHPLACE (State or foreign country) <u>DELAWARE</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES + THOMAS WARD</u>		14. MOTHER'S MAIDEN NAME <u>IDA WILKINS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>ARTHUR WARD. LAUREL Del</u>	
17. INFORMANT Address <u>ARTHUR WARD. LAUREL Del</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>DUE TO</u> (c) <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Portal cirrhosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>25 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/2/58</u> 19 <u>58</u> to <u>11/28</u> 19 <u>58</u> , that I lost saw the deceased olive on <u>11/27</u> 19 <u>58</u> , and that death occurred at <u>8A.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Alberta Mattay</u>		ADDRESS (Street, city or town, state) <u>711 Camden Ave</u> DATE SIGNED <u>11/28/58</u>	
PHYSICIAN'S NAME (Type) <u>Arthur S. Kneel</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/31/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bethesda Ch. Cem</u>		22d. LOCATION (City, town, or county) (State) <u>NEAR LAUREL Del</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kneel</u>		24a. REC'D BY REGISTRAR <u>DEC 2 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneel</u>			

DATE IN USE

DATE OF DEATH

RECEIVED BY

RECEIVED BY

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

10-1-10



13131

CERTIFICATE OF DEATH

13121

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Whitton</u>				c. LENGTH OF STAY IN 1b <u>70 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>MANIE</u> First <u>E.</u> Middle <u>WEBB</u> Last				4. DATE OF DEATH <u>Nov.</u> Month <u>20</u> Day <u>19</u> Year <u>58</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 10, 1868</u>	
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS, OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Marsellus Dennis</u>				14. MOTHER'S MAIDEN NAME <u>Laura Pawell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>1</u>		17. INFORMANT <u>Lillian Morris Pawellville Del</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> DUE TO <u>422.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive Heart Failure</u> DUE TO <u>1 wk.</u> (c) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO <u>? years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X</u> <u>Fractured left hip</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Nov. 15, 1958</u> , to <u>Nov. 20, 1958</u> , that I last saw the deceased alive on <u>Nov. 19, 1958</u> , and that death occurred at <u>9:15 P.M.</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>John M. Bender</u> M.D.				<u>104 Bay St. Snow Hill, Md.</u>			
PHYSICIAN'S NAME (Type) <u>John M. Bender, M.D.</u>				<u>104 Bay St., Snow Hill, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11/22/58</u>		<u>Dennis</u>		<u>Pawellville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Peter Walsh Selbyville Del.</u> ADDRESS				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
				DATE <u>NOV 25 '58</u>		<u>Arthur L. Knecht</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										13122
Items 4, 18 & 20 Film 236 12-5-58 ams										
13111 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b 12		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pen Gen. Hospital					d. STREET ADDRESS 712 Oak Hill Ave.					
3. NAME OF DECEASED (Type or print) HELENA First WELITSCHKO Middle Last					4. DATE OF DEATH Month NOVEMBER Day 28 Year 1958					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 30, 1908		9. AGE (In years last birthday) 50 yrs.		
						IF UNDER 1 YEAR Months 5 Days 27		IF UNDER 24 HRS. Hours Min. 		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Tonowka, Ukrain		12. CITIZEN OF WHAT COUNTRY? D.P. of Ukrain		
13. FATHER'S NAME Timofej Belinka					14. MOTHER'S MAIDEN NAME Natalia (Unk)					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Mr. Nickolaj Welitschko (Father-In-Law) R.D. # 2 Berlin, Maryland						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Periferal circulatory failure 823X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple fractures DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Sudden 1 1/2 hrs.										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in car that ran off road and overturned						
20c. TIME OF INJURY Month. Day. Year 11 PM. 11-27-58			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) Salisbury Wicomico Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE Earl L. Royer M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) Dr. Earl L. Royer					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
DATE SIGNED Nov. 30 / 1958										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF Nov. 30, 1958		22c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery		22d. LOCATION (City, town, or county) (State) Berlin, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY					ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR DEC 3 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18&20 Film 236 12-5-58 ans

13132

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13123

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Salisbury		c. LENGTH OF STAY IN 1b 12 Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mt Hermon Rd		e. STREET ADDRESS / 712 Oak Hill Ave.	
3. NAME OF DECEASED (Type or print) MYCHAJLO WELITSCHKO		4. DATE OF DEATH NOVEMBER 27th 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 1, 1912
9. AGE (In years last birthday) 46 yrs.		10. IF UNDER 1 YEAR 6 Months 26 Days 26 Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Body Repair Man		10b. KIND OF BUSINESS OR INDUSTRY Belichowka, Ukrain	
11. BIRTHPLACE (State or foreign country) Ukrain(D.P.)		12. CITIZEN OF WHAT COUNTRY? Ukrain(D.P.)	
13. FATHER'S NAME Nickolaj Welitschko		14. MOTHER'S MAIDEN NAME Tetiana Semonenko	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Mr. Nickolaj Welitschko (Father) R.D.# 2 Berlin, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Crushed chest and fractured cervical spine Sudden 823X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of car that ran off road and overturned	
20c. TIME OF INJURY Month, Day, Year 11 PM a. m. 11-27-58		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) Salisbury (County) Wicomico (State) Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dr. Earl L. Royer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. Earl L. Royer		DATE SIGNED Nov. 30 /1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 30, 1958	
22c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery		22d. LOCATION (City, town, or county) Berlin, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR DEC 3 '58 DATE DEC 3 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13112

CERTIFICATE OF DEATH

13124

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u> 19X-2 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>Oak Street</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Harry B. Wheeler</u>		4. DATE OF DEATH Month Day Year <u>November 21 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 20 1882</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer for Electric Co</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MD</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas Wheeler</u>		14. MOTHER'S MAIDEN NAME <u>Mary Louise Andrews</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Bertie Wheeler Princess Anne Md.</u>	
17. INFORMANT Address <u>Bertie Wheeler Princess Anne Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Cor Pulmonale</u> 241X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bronchial Asthma</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease; Cerebral Arteriosclerosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David L. [Signature]</u> M.D.		DATE SIGNED <u>Salisbury, Md. Nov 21, 1958</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/23/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Manokin Presbyterian</u>	22d. LOCATION (City, town, or county) (State) <u>Princess Anne Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Herman Princess Anne Md.</u>		24. REC'D BY REGISTRAR <u>Nov 25 1958</u>	
24b. REGISTRAR'S SIGNATURE <u>Caroline L. [Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1915

1915

Name of Deceased		Age		Sex		Race		Marital Status		Occupation		Cause of Death		Date of Death		Place of Death		Signature of Physician		Signature of Registrar	
Marie Worcester		71		F		W		M		H		Heart Disease		Jan 10 1915		Home		J. H. [Signature]		[Signature]	
Theresa Worcester		71		F		W		M		H		Heart Disease		Jan 10 1915		Home		J. H. [Signature]		[Signature]	
Mary Louise Andrews		71		F		W		M		H		Heart Disease		Jan 10 1915		Home		J. H. [Signature]		[Signature]	
[Faint Name]		[Faint Age]		[Faint Sex]		[Faint Race]		[Faint Marital Status]		[Faint Occupation]		[Faint Cause of Death]		[Faint Date of Death]		[Faint Place of Death]		[Faint Signature of Physician]		[Faint Signature of Registrar]	



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13113 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13125

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 1 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Pen Gen. Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsville (Rural) d. STREET ADDRESS R.D.# 2 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) PRESTON LEE WILKINS		4. DATE OF DEATH Month NOVEMBER Day 13th Year 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 28, 1910
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farmer	
11. BIRTHPLACE (State or foreign country) Powellville, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Alison Wilkins		14. MOTHER'S MAIDEN NAME Mary Ellen Hales	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT	
17. INFORMANT Mrs. Stella M. Wilkins (Wife)		R.D.# 2 Pittsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH Instant			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dr. Earl L. Royer		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. Earl L. Royer		DATE SIGNED November 13/1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 16, 1958	22c. NAME OF CEMETERY OR CREMATORY Collins Family Cemetery	22d. LOCATION (City, town, or county) (State) Worcester Co. Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		24a. REC'D BY REGISTRAR NOV 17 '58 24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1911

NO. 1000

Location

Residence

Age

Sex

Marital Status

Occupation

Education

Signature of Medical Examiner

Signature of Coroner

Time

Date

Place

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13114

CERTIFICATE OF DEATH

Reg. Dist. No.

13126

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 1 yr. 28 da.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Carrie Middle - Last Wilson		4. DATE OF DEATH Month November Day 12 , Year 19 58	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 5, 1892
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR: Months 66 Days 66 Hours 66 Min. 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Kent Co., Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joe Woodland		14. MOTHER'S MAIDEN NAME Isabelle Barrell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. --	
17. INFORMANT Deer's Head State Hospital Records, Salisbury, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, general DUE TO (c) -		INTERVAL BETWEEN ONSET AND DEATH 3 days Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) --		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 14, 1957 , to Nov. 12, 1958 , that I last saw the deceased alive on Nov. 12, 1958 , and that death occurred at 3:25 P. M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE L. V. Maldve, M. D.		DATE SIGNED 11/12/58	
PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.		Deer's Head State Hospital	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 17, 1958	
22c. NAME OF CEMETERY OR CREMATORY Union Cem.		22d. LOCATION (City, town, or county) (State) Rural Chestertown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward T. Holloway		24a. REC'D BY REGISTRAR DATE NOV 19 58	
24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF BIRTH	
10. DATE OF BIRTH		11. SEX OF BIRTH		12. AGE AT BIRTH	
13. DATE OF DEATH		14. TIME OF DEATH		15. PLACE OF DEATH	
16. CAUSE OF DEATH		17. MANNER OF DEATH		18. PLACE OF BIRTH	
19. DATE OF BIRTH		20. SEX OF BIRTH		21. AGE AT BIRTH	
22. DATE OF DEATH		23. TIME OF DEATH		24. PLACE OF DEATH	
25. CAUSE OF DEATH		26. MANNER OF DEATH		27. PLACE OF BIRTH	
28. DATE OF BIRTH		29. SEX OF BIRTH		30. AGE AT BIRTH	
31. DATE OF DEATH		32. TIME OF DEATH		33. PLACE OF DEATH	
34. CAUSE OF DEATH		35. MANNER OF DEATH		36. PLACE OF BIRTH	
37. DATE OF BIRTH		38. SEX OF BIRTH		39. AGE AT BIRTH	
40. DATE OF DEATH		41. TIME OF DEATH		42. PLACE OF DEATH	
43. CAUSE OF DEATH		44. MANNER OF DEATH		45. PLACE OF BIRTH	
46. DATE OF BIRTH		47. SEX OF BIRTH		48. AGE AT BIRTH	
49. DATE OF DEATH		50. TIME OF DEATH		51. PLACE OF DEATH	
52. CAUSE OF DEATH		53. MANNER OF DEATH		54. PLACE OF BIRTH	
55. DATE OF BIRTH		56. SEX OF BIRTH		57. AGE AT BIRTH	
58. DATE OF DEATH		59. TIME OF DEATH		60. PLACE OF DEATH	
61. CAUSE OF DEATH		62. MANNER OF DEATH		63. PLACE OF BIRTH	
64. DATE OF BIRTH		65. SEX OF BIRTH		66. AGE AT BIRTH	
67. DATE OF DEATH		68. TIME OF DEATH		69. PLACE OF DEATH	
70. CAUSE OF DEATH		71. MANNER OF DEATH		72. PLACE OF BIRTH	
73. DATE OF BIRTH		74. SEX OF BIRTH		75. AGE AT BIRTH	
76. DATE OF DEATH		77. TIME OF DEATH		78. PLACE OF DEATH	
79. CAUSE OF DEATH		80. MANNER OF DEATH		81. PLACE OF BIRTH	
82. DATE OF BIRTH		83. SEX OF BIRTH		84. AGE AT BIRTH	
85. DATE OF DEATH		86. TIME OF DEATH		87. PLACE OF DEATH	
88. CAUSE OF DEATH		89. MANNER OF DEATH		90. PLACE OF BIRTH	
91. DATE OF BIRTH		92. SEX OF BIRTH		93. AGE AT BIRTH	
94. DATE OF DEATH		95. TIME OF DEATH		96. PLACE OF DEATH	
97. CAUSE OF DEATH		98. MANNER OF DEATH		99. PLACE OF BIRTH	
100. DATE OF BIRTH		101. SEX OF BIRTH		102. AGE AT BIRTH	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13115

CERTIFICATE OF DEATH

Reg. Dist. No. **13127**

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital				d. STREET ADDRESS Locust Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Alberta		First Middle Last Wright		4. DATE OF DEATH Month 11 Day 5 Year 19 58			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11, 25, 1926	
9. AGE (In years last birthday) 31 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Colburn Wright				14. MOTHER'S MAIDEN NAME Sarah Cropper			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Georgia Deal Fruitland Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Rheumatic Valvulitis - insufficiency 401.0 DUE TO (b) Pericarditis; cirrhosis of liver - congestion DUE TO (c) of lungs + liver.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/12 , 19 58 , to 11/5 , 19 58 , that I last saw the deceased alive on 11/5 , 19 58 , and that death occurred at M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE A.C. Mitchell				ADDRESS (Street, city or town, state) 211 Maryland Ave, Salisbury, Md.		DATE SIGNED 11/5/58	
PHYSICIAN'S NAME (Type) H.C. Mitchell, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/9/58		22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary		22d. LOCATION (City, town, or county) (State) Fruitland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Clinton S. Stewart, Salisbury Md				24a. REC'D BY REGISTRAR NOV 12 1958		24b. REGISTRAR'S SIGNATURE Arthur S. Kenna	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

